PRINTED: 12/14/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345489	B. WING	B. WING		C 11/10/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	E	11/10/2	3021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BI	_	(X5) MPLETION DATE
F 000	INITIAL COMMENTS	3	FC	000			
	was conducted from	plaint investigation survey 10/28/21 through 11/10/21. and B5B913. Immediate ied at:					
	K	686 at a scope and severity 725 at a scope and severity					
	_	uted Substandard Quality of nded survey was conducted.					
	4 of the 30 complain substantiated but did	t allegations were I not result in a deficiency.					
	18 of the 30 complai substantiated resulting						
	substantiated.	t allegations were not					
F 550 SS=D	Resident Rights/Exe CFR(s): 483.10(a)(1)		F 5	550		12/	10/21
	self-determination, a access to persons a	Rights. ght to a dignified existence, nd communication with and nd services inside and ncluding those specified in					
	with respect and diging resident in a manner promotes maintenan	ity must treat each resident nity and care for each and in an environment that ce or enhancement of his or cognizing each resident's					
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURI	<del></del>	TITLE		(X6) D	DATE

Electronically Signed 12/02/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345489	B. WING		C 11/10/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262	11/10/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 550	access to quality care severity of condition, must establish and m practices regarding tr provision of services residents regardless of \$483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit \$483.10(b)(1) The factor resident can exercise interference, coercion from the facility.  \$483.10(b)(2) The resident from the facility.  \$483.10(b)(2) The resident from the facility.  This REQUIREMENT by:  Based on record revision and the several section of the supplementation.	ity must protect and the resident.  cility must provide equal a regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.  of Rights.  right to exercise his or her of the facility and as a citizen and states.  cility must ensure that the his or her rights without an discrimination, or reprisal asident has the right to be opercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this are in not met as evidenced	F 55	,		
	feed a resident when her bedside table. The observe her tray but r while staff fed anothe 20 minutes (Resident	her meal tray was placed on ne resident was left to not able to access the meal r resident for approximately #11) and staff stood up feeding him (Resident #6)		accomplished for those residents foun have been affected by the deficient practice: Resident #11 and Resident #6 are nov receiving their meals by the staff, in a manner to ensure the meal tray is not in room until staff is able to aid with meals, and staff will be using a chair to	d to v left	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345489	B. WING			C	
NAME OF D	DOVIDED OD CLIDDLIED	343409	D. WING _	CTREET ADDRESS OFF STATE 710 CO		11/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	JDE		
SATURN N	IURSING AND REHABIL	ITATION CENTER		1930 WEST SUGAR CREEK ROAD			
		-		CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 550	Continued From page	e 2	F 5	50			
	6/24/21 with diagnos	admitted to the facility on is of muscle weakness.		provide meal assistance at e encouraging interaction with during meal assistance, as o NA #5 received 1:1 re-education.	resident of 11/4/21. ation by		
	dated 8/10/21 docum	rterly Minimum Data Set nented unclear speech,		Regional Clinical Nurse (RC 11/04/2021 on Resident Rig	hts, the		
	sometimes understood, usually understands.			resident rights including, pro	•		
	The resident was dep living.	pendent for activities of daily		assistance for dependent re need assistance with meals	, including		
	0 40/00/04 440 00			sitting at eye level while feed	•		
		an observation was done of		ensuring trays are not left in			
		A) #5 place Resident #11 's		dependent resident until me	ai assistance		
	The tray was in the re	side table within her view.		can be provided by staff.			
		nutes while NA #5 feed		# - 2 Address how the facility	v will identify		
	another resident acro			other residents having the p	•		
	another recident dere	are main.		affected by the same deficie			
	On 10/29/21 at 12:20	pm an interview was		Director of Nursing and/or u	•		
		A #5 stated she was not		completed observation roun			
	aware that she shoul	d not leave a meal tray in a		that current residents were r			
		en not ready to feed; it was a		assistance properly, on 10/3			
	dignity issue.	•		Any resident identified need	ing assistance		
				with meals will receive their	meal tray		
	On 10/29/21 at 12:40	) pm an interview was		when staff member is ready	to set tray up		
		cation Aid #1. She was		and able to sit down and fee	d resident		
	_	#6 and stated that the NAs		one on one at eye level.			
		eal tray in front of the					
		pendent until the NA was		# -3 Address what measures	•		
	•	tated she would speak to NA		into place or systemic chang			
	<b>#</b> 5.			ensure that the deficient pra	ctice will not		
	0 Daeidart #0	almostate at the affice of a stiffer and		recur;			
		dmitted to the facility on		All nursing staff, including a			
	1/21/21 with the diag	nosis of muscle weakness.		re-educated by Regional Cli			
	Posidont #6 ! a core	plan last updated on 9/21/21		11/11/2021, on Resident Rig			
	·	•		1			
	activities of daily livin	was dependent for all		residents, who need assista meals, including sitting at ey			
	activities of daily livin	y.		feeding and ensuring trays a			
	Resident #6 ' s quart	erly Minimum Data Set dated		front of a dependent residen			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION  IILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _	B. WING		C 11/10/2021		
NAME OF PE	ROVIDER OR SUPPLIER		<del>                                     </del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	10/2021	
	.07.52.7 0.7 00.7 2.2.7				930 WEST SUGAR CREEK ROAD			
SATURN N	IURSING AND REHABIL	ITATION CENTER			HARLOTTE, NC 28262			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 550	Continued From page	÷ 3	F 5	550				
	10/23/21 documented	I an intact cognition, es of daily living, and active			assistance is provided. Any staff not attending the in-service by, 12/10/2021 will not be allowed to work until the re-education is completed.	,		
	done of Resident #6. and NA #5 was stand him. The tray table w NA had to reach over resident. NA #5 was resident during feedin contact.  On 10/29/21 at 12:20 conducted NA #5. Ship stood to feed a rethe bed was up and the bed was up and the stated she would obtain the stated she would obtain the stated with Medical assigned to resident.	pm an interview was an action Aid #1. She was was and interview was are stated that sometimes are stated that an action Aid #1. She was was and was attended to the was action Aid #1. She was was action Aid #1. She was was was action and stated that the NAs was was action and was action			# - 4 Indicate how the facility plans to monitor its performance to make sure t solutions are sustained; and Include dawhen corrective action will be completed. The Director of Nursing and Unit Managers will observe 5 residents daily for 5 days per week times 3 weeks, the times per week for 4 weeks to ensure the staff is providing proper meal assistant for those resident's requiring assistant with meals. Any deficiencies noted with the addressed immediately and corrective action taken as necessary, which may include disciplinary action. Results will recorded on an audit tool titled "Dining Observation" and presented by the Director of Nursing to the Quality Assurance Performance Improvement Committee meetings monthly x 3 month. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	ates ed.  / en 3 hat ee e II ve be		
F 558 SS=D	Reasonable Accomm CFR(s): 483.10(e)(3)	odations Needs/Preferences	F 5	558	Completion date: 12/10/2021.		12/10/21	
	services in the facility accommodation of re- preferences except w	sident needs and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345489	B. WING		1	C 11/10/2021	
NAME OF PE	ROVIDER OR SUPPLIER	2.2.22	<del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1/10/2021	
	10 7.52.1 0.1 00. 1 2.2.1			1930 WEST SUGAR CREEK ROAD			
SATURN N	IURSING AND REHABIL	ITATION CENTER		CHARLOTTE, NC 28262			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)	
PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 558	Continued From page	e 4	F 5	58			
	This REQUIREMENT by:	is not met as evidenced					
	interview of resident a	iew, observation, and and staff, the facility failed to meet a dependent resident '		F558 – Reasonable Accommo	dations		
	s (Residents #6 and 3 residents sampled.	11) accommodation for 2 of		# 1 - Address how corrective ac accomplished for those residen have been affected by the defic	its found to		
	Findings included:			practice: The Director of Nursing and Re	habilitation		
	Resident #6 was admitted to the facility on with the diagnosis of muscle weakness			Director completed an assessm Resident #6 and #11, for a pad- bell, the appropriate call bell wa	dle call		
		erly Minimum Data Set hat the resident had an		10/29/2021. MA #1, NA#3, received reeduca	ation from		
	, ,	resident required extensive		Regional Nurse Consultant, rela "Reasonable Accommodations resident(s) needs/preferences,	ated to for		
		ed for Resident #6 last vealed the resident required		ensuring the resident can push the call bell allowing independe	or touch		
		s activities of daily living (was		for assistance by resident. This was completed on 11/4/21.			
	done of Resident #6 in his lower extremities and hands with no us	am an observation was in his bed. He had no use of and gross use of his arms se of the fingers (able to had no call light in the room.		# - 2 Address how the facility w other residents having the pote affected by the same deficient p Rehabilitation director complete on 11/11/2021 of current reside identify any resident, who would	ntial to be practice: ed an audit, ents to		
	he had no call light be the button. The resid	am an interview was lent #6. The resident stated ecause he could not press lent had to "holler" (call out) could not always hear him.		touch pad call light, no other reidentified in need of a paddle can current residents have a call be on their ability to allow for them assistance, as of 11/11/21	sident was all bell. ell based		
	get help and that was	would take a long time to a problem when he was in inful pressure ulcers).		# -3 Address what measures w into place or systemic changes ensure that the deficient practic recur:	made to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		С	
		345489	B. WING _			11/	/10/2021
NAME OF P	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE		
SATURN	NURSING AND REHAI	BILITATION CENTER		19	930 WEST SUGAR CREEK ROAD		
				С	HARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 558		rsing Assistant (NA) #3 (night	F	558	At the time of admission, re-admissior		
	shift). NA #3 stated Resident #6 could call out for assistance.  On 10/29/21 at 7:55 am an interview was conducted with Medication Aid #1. MA #1 stated she was familiar with and assigned to Resident				a decline of resident condition, there v be an assessment completed, by licer nurse and/or Rehabilitation Director, to	sed	
					identify proper call light to ensure independence of the resident to reque assistance of needs/preferences.	st	
		vas able to make his needs			The Executive Director, DON, and		
		call staff for assistance. She			Corporate Nurse Consultant will comp	lete	
		ident had no call light due to his			retraining with facility nursing staff,		
	inability to press th	e button.			including agency/contract, on resident rights, including "Accommodation of		
		30 am an observation was			Resident Needs/Preferences" by		
		6 in his bed. There was a			12/10/2021.		
		sitting on the resident 's			# 4 Indicate how the facility plane to		
	to me today, and I	nt commented, "they gave this can press it."			# - 4 Indicate how the facility plans to monitor its performance to make sure solutions are sustained; and Include d		
	On 11/3/21 at 12:3	0 pm an interview was			when corrective action will be complet		
		Director of Nursing (DON) and			The Director of Nursing and/or design		
	1 -	onsultant (CNC). The CNC			will observe delivery of care and		
		as aware of Resident #6 's			interaction of staff with at least 5 resid		
	device was placed	call light and a touch pad call on 10/29/21. The CNC stated			during facility rounds daily times 5 day times 4 weeks, then 3 days per week		
	evaluated whether	ent residents would be a touch pad call device would			weeks. Results of these audits will be recorded on an audit tool, "Observation		
	be a good option.				Call Light Utilization" and presented by Director of Nursing and/or Executive	y tne	
		as admitted to the facility on osis of anoxic brain damage.			Director to the Quality Assurance Performance Improvement Committee meetings monthly x 3 months. The	<b>;</b>	
	Resident #11 's qu	uarterly MDS dated 8/10/21			Quality Assurance Committee will ass	ess	
	documented uncle understood, usuall	ar speech, sometimes y understands. She had a			and modify the action plan as needed ensure continued compliance.		
		ed cognition and was			Completion date: 42/40/2024		
	dependent for activities diagnosis was ano	vities of daily living. Active xic brain damage.			Completion date: 12/10/2021		
	Resident #11 's ur	odated care plan dated 7/11/21					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C 11/10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		11710/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 558	activities of daily living on 10/28/21 at 10:44 observed to be calling lying in her bed and off the pillow and was resident had gross in hands and spastic on Observation of the responded to the approximately 15 millight in the room. The retrieved to assist the On 10/28/21 at 10:44 attempted with Reside speech but was able pillow and struggle to unsuccessfully.  On 10/28/21 at 10:55 conducted with MA # resident had spastic moved in the bed freable to understand yand could make her On 11/3/21 at 12:30 conducted with the Ecorporate nurse constated that staff was inability to press a caresidents (including	dent was dependent for all ng.  D am the resident was ag staff. The resident was her neck was bent to the right is unable to reposition. The novement of her arms and novement of her legs.  Desident revealed the staff had resident 's verbal call for nutes. There was no call he assigned staff MA #1 was her resident.  D am an interview was dent #11. She had garbled to turn her head toward the providence of the pillow.  The stated that the muscles and had to be requently. The resident was ou, was checked periodically,	F	558		
F 580 SS=E		njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F 5	580		12/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _		1	C 1/10/2021	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	consult with the resic consistent with his or representative(s) who (A) An accident involves in injury and his physician intervention (B) A significant charmental, or psychosor deterioration in health status in either life-the clinical complications (C) A need to alter the aneed to discontinuous treatment due to advocommence a new for (D) A decision to transident from the fact §483.15(c)(1)(ii).  (ii) When making not (14)(i) of this section all pertinent informatics available and proving physician.  (iii) The facility must resident and the resident and the resident than there is- (A) A change in room as specified in §483.  (B) A change in regulation (e)(10) of this section (iv) The facility must resident and the resident and th	cation of Changes. nediately inform the resident; lent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a h, mental, or psychosocial reatening conditions or si); eatment significantly (that is, e an existing form of erse consequences, or to em of treatment); or esfer or discharge the fility as specified in iffication under paragraph (g) the facility must ensure that ion specified in §483.15(c)(2) ided upon request to the ealso promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or lent rights under Federal or lons as specified in paragraph n. record and periodically mailing and email) and	F 5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345489		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345489	B. WING		11/10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 580	that is a composite of §483.5) must disclosits physical configurations that comprigant, and must spectroom changes betwounder §483.15(c)(9). This REQUIREMENT by:  Based on record restaff and Medical Donotify the MD when omitted on 2 separation 413, and #14) and fawhen treatments were (Resident #6 and #1 reviewed for notification.  The findings includes 1. Resident #14 was 2/10/21 with diagnost chronic diastolic heat Review of the physic revealed Resident #120 milligrams daily.  Review of a signification (MDS) dated 10/10/21	posite distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various ise the composite distinct fy the policies that apply to een its different locations.  T is not met as evidenced view and interviews with the actor (MD) the facility failed to significant medications were the occasions (Resident #12, ailed to the notify the MD are not provided as ordered 5) for 5 of 5 residents tion.  d:  d:  d:  d:  d:  d:  d:  d:  d:  d	F 580	F-580 PHYSICIAN NOTIFICATION  # 1 - Address how corrective action w accomplished for those residents four have been affected by the deficient practice: Director of Nursing and Corporate Nu Consultant completed a review of the medical record for Resident #12, #13, #14, #6, and #15, to ensure no negati outcomes due to missed medication and/or treatments. The attending physician for these residents were no by the DON and RCN of the missed medications and/or treatments, on 10/29/21. Attending Physician continic current medication and/or treatments ordered, and no new orders were obtained Residents #12, 13, 14, 6 at 15 have been receiving their medicati and/or treatments as ordered by their attending physician as of 12/10/21.  # - 2 Address how the facility will iden other residents having the potential to	nd to rse  ve  tified  ued as ad ons

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _	<del></del>		C 11/10/2021	
	ROVIDER OR SUPPLIER	LITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PROVIDER'S PLAN OF CORRECT  PREFIX  (EACH CORRECTIVE ACTION SHOUL  TAG  CROSS-REFERENCED TO THE APPRODEFICIENCY)		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 580	Continued From page	ge 9	F 5	80			
	and toilet use. The MDS medication review revealed diuretic and opioid medications were received 3 days during the assessment look back period.  The care plan last revised on 10/12/21 identified cardiovascular disease diagnoses as atrial fibrillation, congestive heart failure, and hypertension with the goal for Resident #14 not experience complications through the next review. Interventions included administer cardiac medications as ordered.  A review of Resident #14's MAR for October 2021 revealed on 10/10 and 10/24 the letter N (meaning not administered) was documented under the administration of diltiazem 120 milligrams scheduled at 8:00 AM.  2. Resident #12 was admitted to the facility on 3/13/21 with a diagnoses of type 2 diabetes mellitus and dementia.  Review of the quarterly MDS dated 8/20/21 assessed Resident #12's cognition as being severely impaired and required total assistance with bed mobility, transfers, and toilet use and limited assistance with eating. The MDS medication review revealed insulin injections were given 7 days during the assessment look back period.  The care plan last revised on 5/9/21 identified			RCN completed a review of resident medication/treatme administration records, for the days, on 12/10/2021, to identified omissions, the physician for those residents notified, by the Director of N Regional Clinical Nurse. The completed by 12/10/21. Cu are receiving their medication	ent the past 30 ntify t omissions. e attending s were lursing and/or nis audit will be rrent residents		
				# -3 Address what measure into place or systemic change	s will be put		
				ensure that the deficient pra recur: The director of nursing and/ managers will be reviewing resident medication/treatme previous 24 hours to ensure that residents are receiving	or unit current ent records, for to ensure		
				medication/treatments as or attending physician. If there noted omissions, the license be contacted for re-education that medication/treatment w	dered by their e are any ed nurse will on, verification as		
				administered, and completic documentation.  Director of Nursing and/or R Clinical Nurse completed re with licensed nurses, medic including agency, related to documentation of medicatio administration records. This notification of the Medical D Director of Nursing and Exe if medication or treatments were recommendated.	Regional -education ation aides, timely n/treatment s included, irector, cutive Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
	345489 B. WING		44	C /40/2024			
NAME OF P	ROVIDER OR SUPPLIER	0.10.100		STREET ADDRESS, CITY, STATE, ZIP C		/10/2021	
				1930 WEST SUGAR CREEK ROAD	002		
SATURN N	NURSING AND REHABI	LITATION CENTER		CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	F 580 Continued From page 10		F 58	30			
	diabetes mellitus and uncontrolled blood sugar levels with the goal Resident #12 would have an A1C (a percentage of blood glucose readings over a period of 3 months) be below 6. Interventions included administer hypoglycemic agents and obtain blood sugar as ordered.  Review of physician orders for insulin revealed Resident #12 was to receive aspart subcutaneously per sliding scale started on 3/24/21 and detemir inject 30 units subcutaneously every morning started on 6/24/21 for the diagnosis of diabetes mellitus.  A review of Resident #12's Medication Administration Record (MAR) for October 2021 revealed on 10/10 and 10/24 the letter N (meaning not administered) was documented for the times of 7:30 AM and 11:30 AM under the administration of sliding scale aspart insulin (a fast-acting antidiabetic medication) with no blood glucose readings documented. The letter N was documented under the administration of detemir insulin (a long-acting antidiabetic medication) inject 30 units subcutaneously scheduled at 8:00 AM.			completed timely. Any lice including agency who has a this education by 12/10/21, able to work until education  # - 4 Indicate how the facil monitor its performance to solutions are sustained; an when corrective action will  The Director of Nursing/des audit all medication/treatmetimes/ week for 4 weeks, the week for 4 weeks. The Nu will audit at least 5 records	not received they will not be a completed.  ity plans to make sure that d Include dates be completed.  signee will ent records 5 ien 3 times/ urse Consultant		
				3 months. Results of these recorded on an audit tool ti notification Medication Aud  Director of Nursing and/or will complete a summary of that will be reviewed and dimonthly Quality Assurance Improvement Committee m 3 months. The Quality Ass Committee will assess and action plan as needed to encompliance.	audits will be tled Physician it.  unit manager f audit results, iscussed in the Performance heetings times urance modify the		
	4/9/19 with diagnose and chronic obstruct Review of physician Resident #13 was to	s admitted to the facility on es of type 2 diabetes mellitus tion pulmonary disease.  orders for insulin revealed oreceive aspart 25 units ore meals started on 6/29/21		# 5 - Completion date: 12/	10/21		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING			C 11/10/2021
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	<b>1</b>	11/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From pa a day started on 5/3	ige 11 27/21 for diabetes mellitus.	F 5	80		
	assessed Resident intact and extensive mobility, transfers, review of the MDS	terly MDS dated 8/24/21 #13's cognition as being e assist was needed with bed and toilet use. The medication revealed insulin injections for 7 days during the ack period.				
	diabetes mellitus w would not experien	reviewed on 9/6/21 identified ith the goal Resident #13 ce hypo and/or hyperglycemia view. Interventions included as ordered.				
	revealed on 10/10 a (meaning not admin under the administr aspart inject 25 uni 11:30 AM. The lette	ant #13's MAR for October 2021 and 10/24 the letter N nistered) was documented ration of fast-acting insulin ts scheduled at 7:30 AM and er N was documented under ulin detemir inject 30 units AM.				
	PM with Nurse #1. 10/10/21 and 10/24 typically two nurses was the only nurse on both days. Nurs call the MD and no their medications a	onducted on 10/29/21 at 4:06 Nurse #1 revealed on L/21 she worked on a unit that s were assigned to cover and until approximately 3 to 4 PM e #1 stated she did not think to tify him residents had missed nd stated she was struggling k and felt overwhelmed with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345489	B. WING			C I <b>1/10/2021</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		11/10/2021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 580	Continued From pag	ge 12	F 58	30				
	Director of Nursing (unaware residents of scheduled medication due to insufficient nurse assignment and kep relay a message the coming in early. The of residents on that nurse could complet	on 10/29/21 at 4:30 PM the DON) revealed she was id not receive all their ons on 10/10/21 or 10/24/21 urse staff for an assignment. She was aware on 10/24/21 se to cover the second at in contact with Nurse #1 to second shift nurse was DON stated with the number unit she would not expect one e a 2-nurse assignment and ster residents all their						
	An interview on 11/4/21 at 10:32 AM was conducted with the MD. The MD stated that when the residents missed medications there could be harm for critical medications that were missed. If insulin was not given and the blood glucose was not checked for the ordered sliding scale that would cause harm. The MD stated that staff on later shifts should have seen that medication was not given and tried to give the daily dose of medication. The MD stated he expected the nurse to report the missed medications to him or the Nurse Practitioner and that was not done, and he was not informed there were a lot of errors related to missed medications.							
		admitted to the facility on weakness and pressure						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345489	B. WING _			C 11/10/2021		
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	)E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 580	Resident #6 's quart (MDS) dated 10/12/2 cognition and active  A review of Resident administration record orders for daily woun revealed the followin  Right toes of provided on 10/1/21 10/10/21  Left elbow of provided on 10/20/21  Right 5th to not documented as provided on 10/29  Right ischium as provided on 10/1/21 10/10/21, 10/20/21  Left ischium provided on 10/1/21 10/20/21 - 10/25/21,  Sacrum car provided on 10/6/21 10/25/21, and 10/29/21	d left ischium and sacrum.  erly Minimum Data Set 1 documented an intact diagnosis of pressure ulcer.  #6's treatment I (TAR) for October 2021 Id care treatments. The TAR g: eare was not documented as 1 10/4/21 and 10/6/21 - eare was not documented as 2 1 10/25/21 and 10/29 e (start 10/18/21) care was provided on 10/20/21 -  m care was not documented 21 - 10/4/21, 10/6/21 - 10/25/21, and 10/29/21 n care was not documented as 1 10/4/21, 10/6/21 - 10/10/21, and 10/29/21 e was not documented as 1 10/10/21, 10/20/21 -	F					
	On 10/28/21 at 5:25 conducted with Nurse was assigned on 10/2 assignments and wound care due to a Resident #6 was not	pm an interview was e #1. Nurse #1 stated she 10/21 and 10/24/21 to cover was unable to complete lack of staffing. The TAR for initialed because the care e #1 stated that she informed						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _	B. WING		C 11/10/2021	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STA 1930 WEST SUGAR CREEK CHARLOTTE, NC 28262	ROAD	11/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORREC' CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		
F 580	Nurse #1 stated she physician.  On 11/5/21 at 3:00 p conducted with Nurs the failure to provide in the morning stand meeting where mana.  On 11/4/21 at 2:10 p conducted with the Ecorporate nurse consafter a review of Residocumentation for Onursing staff initials on the completed due to DON stated she was and Nurse #9 that we as ordered.  On 11/4/21 at 11:10 a conducted with the fathat he was not made wound care was not stated if informed, he wounds.  5. Resident #15 was	m an interview was e #9. Nurse #9 stated that wound care was discussed up meeting (daily clinical agement was present).  m an interview was present was present was present was present was present was present interview was birector of Nursing (DON) and sultant. Both staff stated ident #6 's TAR ctober 2021, if there were no documented, the care was binsufficient staffing. The made aware by Nurse #1 bund care was not completed	F 5		EFICIENCY)		
	Resident #15 's qua (MDS) dated 8/8/21 cognition. Pressure Resident #15 's trea (TAR) for September	rterly Minimum Data Set documented an intact ulcer was not coded.  tment administration record and October 2021 included are to his right buttock					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345489	B. WING			C I <b>1/10/2021</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		11/10/2021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 580	as provided on 9/22, 10/6/21, 10/11/21 pr 10/28/21, 10/20/21 - 10/28/21 pm, and 10 On 10/28/21 at 5:25 conducted with Nurs was assigned on 10, 2 assignments and v	ck care was not documented /21 - 9/26/21, 10/1/21 - n - 10/15/21, 10/17/21 - 10/22/21, 10/23/21 pm, 0/30/21 am  pm an interview was see #1. Nurse #1 stated she /10/21 and 10/24/21 to cover was unable to complete	F 58	30				
	Resident #15 was not was not done. Nursi the Director of Nursi Nurse #1 stated that affected the ability to ongoing problem and that care was not be was aware that 10/1 the only days in Octainsufficient staff and reflected in the blank.	care due to a lack of staffing. The TAR for at #15 was not initialed because the care done. Nurse #1 stated that she informed ctor of Nursing (DON) on both occasions.  1 stated that a lack of staffing that the ability to provide care was an problem and management was aware was not being completed. Nurse #1 are that 10/10/21 and 10/24/21 were not days in October 2021 that had ent staff and care was not completed as d in the blank TAR documentation. Nurse d she had not informed the physician.						
	On 11/4/21 at 2:10 pm an reinterview was conducted with the Director of Nursing (DON) and corporate nurse consultant. Both staff stated after a review of Resident #15's TAR documentation for September and October 2021, if there were no nursing staff initials documented, the care was not completed due to insufficient staffing. The DON stated she was made aware by Nurse #1 and Nurse #9 that wound care was not completed as ordered.  On 11/4/21 at 11:10 am an interview was conducted with the facility physician. He stated that he was not made aware that Resident #15's							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345489	B. WING			C I <b>1/10/2021</b>		
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1171072021		
				1930 WEST SUGAR CREEK ROAD				
SATURN	NURSING AND REHABIL	ITATION CENTER		CHARLOTTE, NC 28262				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 580	Continued From page	e 16	F 58	30				
	wound care was not completed as ordered. He stated if informed, he would have assessed the wounds.							
F 677 SS=E		or Dependent Residents	F 67	77		12/10/21		
	out activities of daily services to maintain of personal and oral hyg. This REQUIREMENT by: Based on record revinterview of resident aprovide hair wash and resident (Resident #6 sampled.  Findings included: Resident #6 was adm 1/21/21 with the diag. Resident #6 's care of documented that he wastivities of daily livin resident #6 's quarted to activities of daily livin resident #6 's quarted to activities of multiple.  A review of Resident provided by the facilities 2021 revealed he had 10/20/21, 10/23/21, adocumented as provi	iew, observation, and and staff, the facility failed to do nail care to a dependent of for 1 of 3 residents  nitted to the facility on mosis of muscle weakness.  clan last updated on 9/21/21 was dependent for all g.  erly Minimum Data Set dated do an intact cognition, es of daily living, and active muscle weakness.  #6's shower/bathing sheets by for the month of October do a bed bath on 10/6/21, and 10/27/21. Hair care was		F 677 - ADL Care Provided for Dependent Residents:  # 1 - Address how corrective ac accomplished for those resident have been affected by the deficipractice: Resident #6 was given a showe washed, and nails cleaned on 1 by assigned certified nursing as (CNA). During an interview with of Nursing the resident did state preferred to keep his nails long his hair is washed he requests the placed on his scalp. These preferences have been added to plan.  # - 2 Address how the facility with other residents having the poter affected by the same deficient properties of Nursing and unit man completed observation rounds the any other residents who request care, including shower, nail trim hair washed. Any identified residents	etion will be ts found to cient er, hair was 11/05/2021, esistant h Director e that he and after that grease to his care lill identify ntial to be practice: nagers to identify eted ADL aming, or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING			1	C	
NAME OF D	ROVIDER OR SUPPLIER	3-3-03	5: 11::10		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	10/2021	
NAME OF FI	NOVIDER OR SUFFLIER				, , ,			
SATURN	NURSING AND REHABIL	ITATION CENTER			1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 677	Continued From page	e 17	F	677	,			
	on 10/6/21 and 10/23		, ,	0,,	receive a shower, nails trimmed, and I	nair		
	011 10/0/21 and 10/23	721.			washed by their assigned CNA, on	iaii		
	On 10/28/21 at 10:40	am an interview was			11/11/21			
		lent #6. The resident stated						
		peen washed in a long time.			# -3 Address what measures will be po	ut		
	The resident could no	ot remember when. The			into place or systemic changes made	iΟ		
		e would like to have his hair			ensure that the deficient practice will r	ot		
		. The resident stated the			recur:			
	"staff had not offered	to cut my nails."						
	0= 40/20/24 =+ 40.40	am an observation was			Rehab aide completed a interview with	1		
					current residents, on 11/30/21, to determine preference of their bathing,	and		
	done of Resident #6 while in his bed. The resident 's hair appeared greasy and segmented.				ADL care, including, bathing, nail care			
		ted use of his hands and his			and washing of hair. The director of	,		
		losed. The nails were noted			nursing and unit manager completed a	ì		
	_	ed into his palm. Skin was			new shower schedule based on the			
	intact.				current resident preferences and this v	vas		
					implemented 12/10/21.			
	On 10/29/21 at 7:00 a				Nursing staff, including agency was			
		ng Assistant (NA) #3. The			re-educated on the new shower sched			
	NA stated the nursing	g assistants were e resident 's nails if they			including the importance of providing A care based on resident preference. A			
	were not a diabetic.	_			newly hired nursing staff, including	ıy		
	Resident #6 's nails v	•			agency, will receive this training during	1		
		e of the NA wash and cut			orientation. Nursing staff who did not	,		
	Resident #6 ' s nails \	with the assistance of			receive this education by 12/10/21, will	l not		
	assigned Nurse #6.	The NA stated that residents			be allowed to work, until re-education	is		
	_	when they have a shower.			completed.			
		as bed bound and had						
		ed to have his hair washed			# - 4 Indicate how the facility plans to			
		tated she was not sure when			monitor its performance to make sure solutions are sustained; and include d			
	Resident #6 had his h	iaii wasileu iasi.			when corrective action will be complet			
	   On 11/4/21 at 11·30 a	am an observation and			The Director of Nursing or designee w			
		of Resident #6 in his bed.			audit shower documentation sheets, fi			
		changed with a greasy			times per week x 4 weeks then three			
		segmented. The resident			times a week x 4 weeks.			
	stated he had not had	-			A summary of these audits will be			
					completed by the director of nursing o	٢		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345489	B. WING		C 11/10/2021		
	ROVIDER OR SUPPLIER	LITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	,,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 677	corporate nurse cons were made aware th due to insufficient sta aware that hair and i for Resident #6 and	m an interview was Director of Nursing (DON) and sultant. Both staff stated they at care was not completed affing. The DON was made hail care were not completed agreed care should be done.	F 6	designee and results will be review discussed in the monthly Quality Assurance Improvement Committee meeting times 3 months. The Qua Assurance Committee will assess modify the action plan as needed ensure continual compliance.  # 5 - Completion date: 12/10/202	ee ality and to		
F 686 SS=K	CFR(s): 483.25(b)(1 §483.25(b) Skin Inte §483.25(b) Skin Inte §483.25(b)(1) Pressi Based on the compresident, the facility in (i) A resident receive professional standar pressure ulcers and ulcers unless the indicensurates that the (ii) A resident with princessary treatment with professional star promote healing, prenew ulcers from devices This REQUIREMENT by:	grity ure ulcers. ehensive assessment of a must ensure that- es care, consistent with ds of practice, to prevent does not develop pressure lividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to event infection and prevent eloping. T is not met as evidenced	F 6		12/10/21		
	interviews with resid- Family Nurse Practit facility failed to: asse consistently; provide ordered; and provide equipment that opera manufacturer's inst to the development of	view, observation and ent, staff, guardian, Wound ioner and physician, the ess and document wounds wound treatments as e pressure relief from ated in accordance with ructions. These failures led of new wounds, wounds that d became infected (#6 and		# 1 - Address how corrective action be accomplished for those resider found to have been affected by the deficient practice:  Resident #6 was readmitted with diagnosis: chronic osteomyelitis, eurinary retention, and pressure ulcomplete TARS reveal scattered missing work treatments during the last month. discharged to the hospital on 10/1	epilepsy, cer. bund He was		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		, ا	C	
		345489	B. WING			l	10/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SATUDNIA	URSING AND REHABI	I ITATION CENTER		19	930 WEST SUGAR CREEK ROAD			
SAIURNI	IONSING AND REHABI	LITATION CENTER		С	HARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	interventions. These sampled residents we Resident #6 developed and sacrum that beconsteomyelitis of the finadequate pressure #6 required hospitality osteomyelitis with interested in surgitation of the high this resulted in surgitation on the high this resulted in surgitation of the high this resulted in the high th	at resulted in hospital e problems affected 2 of 3 with pressure ulcers. and a new pressure ulcer on d larger wounds on the hips mame infected, acquired doe and expressed pain from a relief while in bed. Resident reation for treatment of the travenous antibiotics. Apped a new wound that mest stage with infection. It ical debridement and hospital  began on 9/22/21 for the facility failed to provide at for skin abrasion of his and in a black necrotic are ulcer the size of a fist that bridement. Immediate 0/11/21 for Resident #6 when able ulcer required ablication. Immediate jeopardy 7/2021 when the facility ble allegation of immediate the facility will remain out of the rescope and severity level of the apotential for minimal mediate Jeopardy) to ensure the sare put in place and to in-service.	F	686	treatment of a declining wound and readmitted on 10/18/2021. On 10/29/2021, it was noted that his air mattress had malfunctioned, and it was replaced. Resident # 6 was assessed fourrent wounds and treatments on 11/5/2021 by wound nurse practitioner, treatment nurse and nurse consultant. Treatment orders are to continue, at the time, after reevaluation. Air mattress is functioning properly and checked every shift for continued function and residen noted to be comfortable during wound evaluation.  Resident #15 was originally admitted on 05/02/2018 with diagnosis: multiple sclerosis, failure to thrive, and pressure ulcer. Wound was noted on 9/22/2021 extend to the right ischial area with identification of the right buttock which noted in the residents' wound records a Stage 4. Resident was transferred to the hospital for left sided facial drooping and increased aphasia while participati in therapy. During hospitalization it was noted that resident's wound had necrot eschar and wound was debrided during this hospitalization. Resident was readmitted on 10/28/2021 with new ord for wound which were initiated. Reside was seen by in-house treatment nurse and wound nurse practitioner on 11/05/2021, to ensure wound measurements, current treatment orde are appropriate to promote healing. Resident was comfortable and had no	or is is it		
	ulcers to his right and	d left ischium and sacrum.			pain with treatment provided. Air mattre initiated and functioning properly on	ess		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345489	B. WING			C	
NAME OF PE	ROVIDER OR SUPPLIER	0.0.00	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	•	1/10/2021	
INAME OF T	COVIDENCE ON GOLF EIEN				JOBE		
SATURN N	IURSING AND REHABIL	ITATION CENTER	1930 WEST SUGAR CREEK ROAD				
				CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 686	Continued From page	⊋ 20	F 68	86			
		ssion Minimum Daily Set documented he had an intact		11/06/2021.			
	cognition. He had bo	wel incontinence. He had		# 2 - Address how the facil	ity will identify		
	one stage 4 pressure	ulcer and 6 unstageable		other residents having the	potential to be		
	pressure ulcers with	suspected deep tissue injury.		affected by the same defici			
				The Facility has employed			
		erly MDS dated 5/10/21		wound Nurse for the facility			
		2 stage 3 pressure ulcers, 3		New would care provider is	•		
		ers, and 3 unstageable		as of 11/5/2021. The Corpo			
	He had bowel inconti	suspected deep tissue injury.		Nurse completed a Compe facility wound nurse and D	-		
	ne nau bowei inconti	nence.		Nursing to ensure they we			
	Resident #6 's physic	cian order dated 6/19/21		wound identification, meas	•		
		with betadine daily for deep		treatments and healing.	aring,		
	tissue injury.	,		The Director of Nursing an	d		
	, ,			Administrative Nurses com			
	Resident #6 's physic	cian order dated 7/12/21 for		to- toe assessment of curre			
	the right ischium was	to clean with wound		11/04/2021, to evaluate cu	rrent skin		
		it dry. Pack with wet Dakin '		condition and identify any r			
	_	e and cover with dry sterile		deficiencies. Any areas ide			
	dressing (DSD).			cross referenced with resid			
				Treatment Administration F			
	Resident #6 's physic			ensure treatments were in	•		
		eft ischium clean with wound		being implemented timely.	•		
	s solution gauze and	t dry. Pack with wet Dakin '		that would have been ident			
		dent #6 's physician order		resident's attending physic been notified and treatmen			
		sacrum was to clean with		obtained. There were no r			
		and pat dry. Pack with wet		noted.	icw arcas		
	•	ize and cover with DSD.		11/4/2021, Regional Clinica	al Nurse		
				completed a review of nurs			
	Resident #6 's care p	olan last updated for		the last 30 days. No new o			
	· · · · · · · · · · · · · · · · · · ·	21/21 documented that he		noted. This included, an au			
	•	o his left heel, right toes, left		previous weeks' wound pro			
		ım, and sacrum. The right		reviewed for current wound	-		
		crotic tissue, unstageable,		were updated as applicable	e. This also		
	, ,	. Interventions for pressure		included updating resident	•		
	ulcers were pressure	reduction device and		care guides to ensure inter			
	turning.			each resident to prevent ar	nd treat		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _				C / <b>10/2021</b>	
NAME OF PR	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	71072021	
				19	930 WEST SUGAR CREEK ROAD			
SATURN N	IURSING AND REHAE	BILITATION CENTER			HARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	to enhance healing The manufacturer i supervision was newith disability. The according to the pelevel in conjunction manufacturer 's coprovided the inflation person's weight. Sight for malfunction the pump unit shout prevent bedsores for the wound care fall progress note dated #6's wound to sact length 6 centimeter 2 cm. There was no skin in one direction serosanguinous dra (opening under the direction) at 9 o'clinis left ischium was width 2.1 cm, and of yellow necrotic tiss serosanguinous dra ischium was stage 1.5, and depth 1 cm tissue. There was pressure ulcer but sacral ulcers had in	ssure ulcer reduction bed was and prevent skin breakdown. Instructions indicated close leded when used by a person mattress inflation level was been and weight and comfort with the physician. The mfort and weight level table for recommendation by the Service and malfunction will and the mattress. Warning: ald always be operating to from occurring.  In of the mattress. Warning: ald always be operating to from occurring.  In of the mattress warning: all always be operating to from occurring.  In of the mattress warning: all always be operating to from occurring.  In of the mattress warning: all always be operating to from occurring.  In of the mattress warning: all always be operating to from occurring to from occurring.  In of the mattress warning: all always be operating to from occurring to from occurring to from occurring.  In of the mattress warning: all always be operating to from occurring to from occurring to from occurring to from occurring to from one occurring.  In of the mattress warning: all always be operating to from occurring	F	686	pressure ulcers.  # 3 - Address what measures will be printo place or systemic changes made the ensure that the deficient practice will near recur:  The facility wound care nurse and/or designee will be providing weekly roun for any residents identified with an identified wound, to evaluate status, including measuring, treatments, and healing. Any newly identified resident wat a wound, the wound care nurse will not the resident attending physician to ensuppropriate treatment is implemented, timely. At the time of new resident admission, the facility licensed nurse is required to complete a body assessment to identify resident skin integrity and are identified concerns, will be discussed with attending physician for an immedia intervention, treatment order to promote healing.  On 11/4/2021, all residents with air mattresses were observed for function equipment by the director of nursing an administrative nurses. Orders were added to check function every shift by license nurse, and documented on the resident electronic treatment administration reconstruction.  Director of Nursing, unit managers, and	o ot		
	scabbed.  The wound care fair progress note date.	e, were unstageable, and mily nurse practitioner d 9/20/21 documented elbow was an unstageable			licensed nurses, including agency, hav received re-training by the Regional Clinical Nurse, on process of full body skin assessments x three (3) days upo admission and then weekly skin audits 11/06/2021, by the Regional Clinical	n		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDII	_			С
		345489	B. WING _			1	/10/2021
NAME OF P	ROVIDER OR SUPPLIER	<b>L</b>	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11	71072021
					930 WEST SUGAR CREEK ROAD		
SATURN I	NURSING AND REHA	BILITATION CENTER			CHARLOTTE, NC 28262		
(V4) ID	SLIMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(YE)
(X4) ID PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	Continued From p	age 22	F 6	686			
	skin tear and had	length 2.5 cm, width 1.6 cm,			Nurse. Newly hired facility nursing sta	aff,	
		No tunneling was observed			including agency will be provided this		
	and had mild sero	us draining. The sacrum			education by the facility Director of		
	wound was stage	4 and had length 6.1 cm, width			Nursing/designee during their orientati	on	
	3.4 cm, and depth	1.9 cm. There was			period. Any licensed nurse who have		
		o ' clock at 1.1 cm. No tunnel			received this education by 12/10/21, w	/ill	
		yellow necrotic tissue. There			not be allowed to work.		
	was moderate ser						
		the left ischium was a stage 4			Director of Nursing/designee complete		
	pressure ulcer and			all current residents Braden assessme			
		cm. No tunneling was necrotic tissue was present.			to identify any risk for wound developr		
		l ischial wounds were			by 11/6/2021. Assessments will continuous quarterly and with any change in	iue	
		oes all had black necrotic tissue			condition. Verified completion was		
	and unstageable.	ood all flad black floored tibeac			conducted by Regional Clinical Nurse	on	
	<b>3</b>				11/06/2021. Effective 11/6/2021, facili		
	Resident #6 's tre	atment administration record			nursing staff, including agency will not	•	
	(TAR) for October	2021 revealed several			allowed to work until education has be		
	treatments were n	ot signed as completed.			completed by Director of Nursing/designee.		
	The right toes had	I an order dated 6/20/21 to paint			Transing/designes.		
		h day scheduled at 2:30 pm:			# 4 - Indicate how the facility plans to		
		0/4/21 and 10/6/21 - 10/10/21			monitor its performance to make sure	that	
	had no initials dod	cumented for care completed.			solutions are sustained; and Include		
					dates when corrective action will be		
	The right ischium	had an order dated 7/22/21 to			completed:		
		with wet Dakin 's 0.5% solution			Effective 11/6/2021, the Nurse		
	· ·	ition) and cover with a DSD.			Management Team (to include Directo		
		tials entered for care completed			Nursing, Unit Managers), will review in		
		ock for 10/1/21 - 10/4/21 and			clinical morning meeting new admission	ıns,	
	10/6/21 - 10/10/21	l <b>.</b>			discharge summaries for any hospital		
	The left icebium b	ad an order dated 7/22/24 to			identified wounds, weekly skin audits,		
		ad an order dated 7/22/21 to			wound MD progress notes and daily treatment administration records, to		
		with wet Dakin 's 0.5% solution OSD. There were no initials			ensure residents are receiving treatme	nte	<b> </b>
		ompleted on the 2:30 pm block			to promote healing of current wounds.		
		21 and 10/6/21 - 10/10/21.			The audits will be documented on the		
	.51 15/1/21 15/4/	10,0,21 10,10,21.			Clinical Rounds Checklist five (5) x's p	er	
	The sacrum had a	n order dated 7/12/21 to			week x twelve (12) weeks. The Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			11/1	) 10/2021	
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE	E, ZIP CODE	1 11/1	10/2021	
				1930 WEST SUGAR CREEK R	ROAD			
SAIURNI	NURSING AND REHABII	LITATION CENTER		CHARLOTTE, NC 28262				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI' CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From pag	e 23	F 6	886				
F 000	cleanse with wound of 0.5% solution and convere no initials enter 2:30 pm block for 10, 10/10/21.  On 10/28 at 5:25 pm with Nurse #1. Nurse initialed because the A nurses I note date the facility nurse prace #6 Is pressure ulcers right toe declined and order to send the resprovided.  Resident #6 was hose 10/18/21 for treatment toe.  The hospital discharge for Resident #6 docuright toe was infected osteomyelitis (infection The resident remains antibiotics and was dwith continued antibiosacral pressure ulcers Resident #6 Is TAR readmission to the faction alignate, and were no initials enter	cleanser daily wet Dakin's over with a DSD. There sed for care completed on the 1/1/21 - 10/4/21 and 10/6/21 -  an interview was conducted se #1 stated the TAR was not wound care was not done.  d 10/11/21 documented that citioner observed Resident so and determined that the dappeared infected. An sident to the hospital was spitalized from 10/11/21 until not of his infected right foot ge summary dated 10/18/21 amented that the resident's did, and he had acquired an on of the bone) to that toe. Sed admitted for intravenous lischarged back to the facility otics. The ischiums and res were stage 4.  documentation after accility was as follows.  In order to cleanse, apply did cover with DSD. There are done to the state of the core of	F6	Nursing and/or Unit Mocomplete a summary will be reviewed at the Assurance Performance Control of the Assurance Performance Control of the Assurance Improvementing was held on Ad-hoc Quality Assurance Improvementing will be held of Director of Nursing work correction to QAPI control of the Assurance Improvementing will be held of Director of Nursing work correction to QAPI control of the Assurance Improvement and any furtance Improvement and any furtance Improvement Improveme	of audit results the monthly Quality mee Improvement X 3 months. The momittee will assert plan as needed to a pliance.  Trance and mement (QAPI) 11/06/2021. An ance and mement (QAPI) months on 11/6/2021. The months of the mont	ess co		
	were no initials enter							

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION			PLETED
		345489	B. WING _			1	C / <b>10/2021</b>
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, C 1930 WEST SUGAR CHARLOTTE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH (	VIDER'S PLAN OF CORRECTIOI CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pag	e 24	F	686			
	betadine daily. The care completed on the 10/25/21 and 10/29	I an order to paint with re were no initials entered for ne 2:30 pm block for 10/20/21 0/21. d an order to cleanse and					
	pack wet with Dakin DSD daily. There w	's solution and cover with vere no initials entered for ne 2:30 pm block for 10/20/21					
	pack wet with Dakin DSD daily. There we	an order to cleanse and 's solution and cover with ere no initials entered for care 30 pm block for 10/20/21 - 21.					
	cleanser, pack wet v cover with DSD. Th	order to cleanse with wound with Dakin 's solution and here were no initials entered on the 2:30 pm block for and 10/29/21.					
	with Nurse #1. Nurse assigned two nursing 10/10/21 and 10/24/2. Nurse #1 was asked assignment for even to a lack of staffing costated that her additional to the stated that she was care and supervision Resident #6's air mappropriate pressure.	g units due to lack of staff on 21 for day shift 7 am to 3 pm. to stay for one nurse ing shift 3 pm to 11 pm due on the same days. Nurse #1 onal day shift assignment 6's wound care. Nurse #1 not able to provide wound in (to include checking attress inflation device for e) to any of the residents on					
	Resident #6 's wour	ment, which included nd care. Total residents for nents were more than 30					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345489	B. WING	_		44/	
NAME OF P	ROVIDER OR SUPPLIER	0.0100		S	TREET ADDRESS, CITY, STATE, ZIP CODE	111/	10/2021
					930 WEST SUGAR CREEK ROAD		
SATURN	IURSING AND REHABIL	ITATION CENTER			HARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	(TAR) was not initialed done. Nurse #1 stated that a Director of Nursing (ENurse #1 stated that a ongoing problem and that care was not being was aware that 10/10 the only days in Octoinsufficient staff and coreflected in the blank.  On 11/4/21 at 2:10 proconducted with the Doconducted with the Doconsultant. Both starkesident #6's TAR of 2021, if the resident would be a star in the no nursing staff initial not completed due to DON stated she was care was not completed when it happened. If first three weeks in Off family nurse practition the assigned resident assessed and measured that there nurse and assigned measured the resider October.  Resident #6's quarter 10/23/21 documented ulcers with four preservant.	ment administration record d because the care was not ad that she informed the DON) on both occasions. It alack of staffing was an amanagement was aware and completed. Nurse #1 1/21 and 10/24/21 were not ber 2021 that had care was not completed as TAR documentation.  In an interview was ON and Corporate Nurse of stated after a review of documentation for October was out of the facility there initial box and if there were is documented, the care was insufficient staffing. The made aware that wound and as ordered, not always the DON stated that for the ctober 2021 the wound care her was not available, and its wounds were not red during this time. The ewas not a wound care her was not a wou	F	686			
	The care plan was no	t updated after					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C 11/10/2021	
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, 1930 WEST SUGAR CREEK RO. CHARLOTTE, NC 28262		11/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)	DATE.	
F 686	hospitalization.  The wound care family progress note dated elbow pressure ulcer length 2.6 cm, width 0.7 There was scant serowas declining. Sacrawidth 5.1, and depth 6.4 cm (new). Around was yellow necrotic tifoul-smelling drainage declining. The left isowidth 4.4 cm, and dewound was red. There with minimal serosany wound was declining. length 4.1 cm, width 4.4 cm, width 4.4 cm, width 4.4 cm, and the wound was declining. In the wound was declining. The wound toes: 2nd, 3rd, and 4th declining. There was no drainage.  On 10/28/21 at 10:10 done of Resident #6 in mattress bed. The releft leaning on his left air flow pressure deviared light on "mainter pressure by weight has pounds (lbs). The restored to the bed to the b	ly nurse practitioner 10/26/21 documented right (started as a skin tear) had 0.8 cm, and depth 0.1 cm. The sus drainage, and the wound I wound had length 7.3 cm, 3.2. There was a tunnel of the wound was red. There is sue and moderate is. The wound was red. There is sue and moderate is. The wound was red. There is a red. Around the re was yellow necrotic tissue red. The right ischium had 1.2 cm, and depth 3.1 cm. It is red. There was yellow inimal serosanguinous was declining. Right foot in toes were now open and 100% necrotic tissue with a man observation was in his pressure reduction air resident was slightly off to his reliable. Observation of the ce for the mattress indicated nance" and the light for red indicated less than 100 red indicated les	F	586			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345489	B. WING			C 11/10/2021
	ROVIDER OR SUPPLIER	ILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZII  1930 WEST SUGAR CREEK ROAI  CHARLOTTE, NC 28262	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	-	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 686	conducted with Rescomplained that his hurting and thought had been soft." The He stated that he haskin. The resident so not always changed had received his pauncomfortable on the On 10/28/21 at 12:1 done of Resident #6 mattress bed. The left leaning on his leair flow pressure de a red light for "main pressure by weight lbs.  On 10/28/21 at 2:40 of Resident #6 in his mattress bed. The left leaning on his leair flow pressure de a red light for "main pressure by weight lbs.  On 10/28/21 at 2:40 of Resident #6 in his mattress bed. The left leaning on his leair flow pressure de a red light for "main pressure by weight lbs.  On 10/28/21 at 4:10 conducted with Nursesident #6. She se check Resident #6 see if it was lit. She device had a mainten not know who would mattress air pressur maintenance. She is marked to the see if it was lit. She device had a mainten not know who would mattress air pressur maintenance. She is conducted with not know who would mattress air pressur maintenance. She is conducted with not know who would mattress air pressur maintenance. She is conducted with not know who would mattress air pressur maintenance. She is conducted with not know who would mattress air pressur maintenance. She is conducted with not know who would mattress air pressur maintenance. She is conducted with not know who would mattress air pressur maintenance. She is conducted with not know who would mattress air pressur maintenance. She is conducted with not know who would mattress air pressur maintenance.	0 am an interview was ident #6. The resident sacral pressure ulcer was the mattress was "soft and e resident did not know why. ad several open areas in his stated that his dressings were in The resident stated that he in medication but was	F	686		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345489	B. WING _			C 11/10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE 1930 WEST SUGAR CREEK RO CHARLOTTE, NC 28262		11710/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B D TO THE APPROPRI/ ICIENCY)	DATE
F 686	of Resident #6 on his mattress bed. The releft leaning on his lef air flow pressure deva a red light on "mainted pressure by weight wilbs.  On 10/29/21 at 6:45 of Resident #6 in his reduction air mattress pressure monitor red longer lit. The press at 1000 lbs.  On 10/29/21 at 7:00 conducted with Nurs assigned to Residen at the air mattress or was lit and observed interview. (Nurse #6 to 1000 lbs).  On 10/29/21 at 7:55 conducted with the A Coordinator/Medicat assigned to Residen the resident was on a mattress and looked device at the end of but that it was provid setting was set to 10 pressure device durin commented if the presetting for the resident resident was on the resident was set to 10 pressure device during the resident was set to 10 pressure device during the resident was set to 10 pressure device during the resident was provided to the	pm an observation was done is pressure reduction air esident was slightly off to his it elbow. Observation of the rice for the mattress indicated enance" and the light for was indicating less than 100 am an observation was done bed. The pressure is was inflated, and the imaintenance light was no ture light indicated it was set am an interview was in the ending was not aware that it was set am an interview was in the control device during was not aware that it was set am an interview was et am an interview was et am an interview was et am an interview was control device to make sure it the control device during was not aware that it was set am an interview was et at the pressure regulation the bed, not just that it was lit ing proper pressure. The oolbs. She observed the ing interview and had not essure was set at the proper int.	F	686		
	commented if the presenting for the reside	essure was set at the proper				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C 11/10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	DDE	11/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C  X (EACH CORRECTIVE ACTIC  CROSS-REFERENCED TO TH  DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 686	provided by Nurse # pressure ulcers to the were deep and with infection. Nurse #7 pressure reduction resource reduction resource at 1000 lbs. Nu 200 lbs to match up weight. The resident center almost to the stated that there was resident 's torso. The took a picture of the and serial number. The air mattress devineed to be replaced 1000 lbs was not the Resident #6.  On 10/29/21 at 12:11 conducted with the Idid not know the air working until today at long it had not been not reported that the maintenance mode. Resident #6 's presentat the pressure reduction.	's wound care. Care was '7. She commented that the re sacrum and 2 ischiums out signs and symptoms of observed and unlocked the mattress because the setting rese #7 changed the setting to closer to the resident's ream of the bed. Nurse #7 s an air mattress beneath the re DON entered the room and air mattress pressure device The DON commented that rece was broken and would recorrect pressure for  O pm an interview was OON. The DON stated she mattress device was not and she did not know how operating correctly. Staff had	F	52.00.2.0		
	On 10/29/21 at 1:40 conducted with the v practitioner for Resident #6 was ass 10/26/21 and all pre She stated that an ir bed that was too sof	ould be replaced. pm an interview was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345489	B. WING				C 10/2021	
	ROVIDER OR SUPPLIER	LITATION CENTER	,	STREET ADDRESS, CIT 1930 WEST SUGAR C CHARLOTTE, NC 2	REEK ROAD	,	10,202	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD E FERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE	
F 686	Resident #6 was a h sepsis and daily wou prevent infection. Si pressure reduction a would be expected to was aware that there measurements of the followed for wound followed by teleph. He stated that an air bed was for pressure was too soft or too h cause undue pressure. On 11/4/21 at 11:10 conducted with the followed for missed, to infected or worsen (I was not made aware care was not complete.)	ssue. She stated that igh risk for infection and and care was important to the stated that without and wound care the wounds to decline. She stated she were no assessments and the residents that were being for the prior 3 weeks to the was unavailable.  am an interview was one with the facility physician. If the mattress ard (not operating), it would be read injury.  am an interview was acility physician. He stated that he wound could become arger). He stated that he at that Resident #6's wound sted as ordered and was ent was hospitalized for his	F	886				
	pressure ulcers had practitioner visit of 10 residents informed he care and the assigner resident they would He stated that the fafor Resident #6 cont 2. Resident #15 was	1) and was aware that all the declined (wound nurse 0/26/21). He stated that im they waited for wound ed nurse informed the return but had not returned. illure to provide wound care ributed to his infection.  admitted to the facility on noses of neurological disorder es.						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE COMP	SURVEY PLETED
		345489	B. WING _				C <b>10/2021</b>
	ROVIDER OR SUPPLIER	LITATION CENTER		1930 W	T ADDRESS, CITY, STATE, ZIP CODE VEST SUGAR CREEK ROAD LOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From pag	e 31	F	886			
	_ ·						
	Resident #15 's adm documented he was ulcer.	nission Braden Scale a high risk for pressure					
	onset dated 5/9/19 a related to his diagnos	entions included weight shift					
	#9 dated 9/22/21 dod (ischium) open area	ses ' note written by Nurse cumented right buttocks noted that went from skin quickly, in a matter of days.					
	Resident #15 was pla new order Physician written for wound car cleanse with wound of medi-honey, and cov	aned with necrotic tissue.  anned for surgical consult. A order dated 9/22/21 was te to right buttock was cleanser, pat dry, apply yer with a dry sterile dressing If as needed for soiling.					
	was assigned to Res the skin abrasion to t covered with a DSD Medi-honey and dres day. On 9/22/21 Nur Resident #15 's isch declined to a black no	m an interview was e #9. She stated that she ident #15. She had identified the ischium which she that was now a stage 2 and ssing was ordered for each rse #9 stated she observed ium wound which had ecrotic unstageable pressure fist. The facility nurse					

OLIVILIY	OT OIL MEDIO/IILE A	MEDIO/ ND CEITTICE				OIVID ITC	7. 0000 000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	c
		345489	B. WING				10/2021
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SATURNA	IURSING AND REHABIL	ITATION CENTER		1	930 WEST SUGAR CREEK ROAD		
OAI OI (III )	TORONO AND REHADIE	ALIGN GENTER		(	CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	and assessed the result and assessed and	med of the wound decline sident by video. The facility we orders for a surgical infection and needed ar tissue. Nurse #9 informed that Resident #15 had not on several occasions in urse #9 stated that she was re was not being completed ffing and observed on the g had not completed wound ed. Nurse #9 would round nurse practitioner each week R. Nurse #9 stated that the initialed as being completed After Nurse #9 stated she ere no initials, she was hat the care was not 0 stated she informed the DON) of the failure to provide the residents on multiple th of September 2021. In the failure to provide wound in the morning stand up I meeting where esent). Nurse #9 stated that that wound care was not use #9 had changed her of as needed and had not	F	686	,		
	Resident #15 's TAR	for October 2021					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345489	B. WING _			C <b>11/10/2021</b>	
NAME OF PROVIDER OR SUPPLIER  SATURN NURSING AND REHABILI	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	DE	11/10/2021	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA	D 4TE	ON
2:30 pm. There were dated 10/1/21 - 10/6/2 block for remainder of hospitalization).  Resident #15 's nurse documented he was so of the pressure ulcer sthe wound nurse prace.  Resident #15 's disch documented an intact (ischium) pressure ulcer sthe wound intection debridement.  Resident #15 's hospidated 10/7/21 docume for a worsening pressideep wound infection debridement.  Resident #15 's facility progress note dated 1 sacral wound after deathere was skin breaked buttocks. The resider last week (before debeschar circular of righted evidence of purulent of Resident was sent to for the black eschar a (10/7/21). The wound serous drainage and won ocurrent signs of infelevated which cell con Resident #15 's physindicated to clean the	right buttock as ordered at no initials for care provided 21 (star in signature/initial if the month for 10/7/21  es' note dated 10/6/21  est out for surgical consult stage "5" ischium wound per titioner.  harge MDS dated 10/6/21  cognition and stage 4  cers.  ital history and physical ented inpatient admission ure ulcer now a stage 4 with Plan for operative  ty nurse practitioner's 0/11/21 for follow-up on bridement documented lown to sacrum and right of 's wound was examined ridement), and it had black to buttock and there was drainage on his dressing. the hospital for debridement	F6	586			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED		
		345489	B. WING _			C 11/10/2021	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		11710/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	Continued From pag	ge 34	F 6	86			
	order beginning 10/r for care provided 10 a day dressing, no in twice a day dressing 10/22/21 for twice a for 10/23/21 in the p Resident #15's faci progress note dated up for decubitus ulca ago the resident had ordered wound care closely. Order for D pack with Dakin's viday.	lity nurse practitioner 10/18/21 documented follow er. Approximately 2 weeks I surgical debridement. She nurse practitioner to follow akin 's solution cleanse and vet-to-dry dressing twice a					
	nurse practitioner.  Resident #15 's phy 10/25/21 documenter mental status, low opulse of 102 and bloresident was sent to Resident #15 's disc 10/28/21 documenter as sepsis, acute encenzymes (shows injurate. Antibiotic coversuspected sacral ulcomphysical therapy reconstructions wheelchair to get the ulcer.	charge summary dated ed the resident 's diagnoses cephalopathy, elevated heart cury), and fast ventricular heart crage was provided. Cer infection. Hospital ommended a motorized e resident up off his sacral					
	Resident #15 's phy	sician order dated 10/28/21					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345489	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		11/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 686	clean with Dakin's as-soaked gauze and day.  Resident #15's TAF began 10/28/21 had except for 10/28/21 pm.  On 11/3/21 at 2:02 pconducted with the Cparty) for Resident #resident acquired a pthat quickly worsene informed her his woccompleted regularly bed. The resident hadebridements to his due to infection and change. The resider and was at risk for some of the first that if the wound care ordered or missed, the infected or worsen, made aware by the first wound care was not was aware that the resident and was a trick that the resident and was aware that the resident and was a trick that the resident and was a	and stage 4 pressure ulcer and pack with Dakin ' cover with a DSD twice a R for October of 2021 order initials for care provided 10:30 pm and 10/30/21 2:30 m an interview was Guardian/RP (responsible 15. The RP stated that the pressure ulcer in September d. The resident had and care was not being and he was not getting out of as had to have two ischium/sacral pressure ulcer necrotic tissue which was a not had advancing disease epsis.  am an interview was acility physician. He stated e was not completed as the wound could become He stated that he was not racility that Resident #15 ' s completed as ordered and	F 6				
	nurse stated to resid had not returned who the day. The physic residents informed h to provide wound ca	vound care. The assigned ents they would return and en I saw the resident later in ian did not indicate which im. He stated that a failure re would be a contributor to cian was informed that an					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C <b>11/10/2021</b>	
	ROVIDER OR SUPPLIER	LITATION CENTER	1	STREET ADDRESS, CITY, STATE, Z 1930 WEST SUGAR CREEK ROA CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE CROSS-REFERENCED			
F 686	An interview was atta practitioner on 11/4/2 was not able to be le supervising facility pl 11/4/21 by telephone was provided from the physician.  On 11/4/21 at 2:10 p conducted with the E consultant. Both state the resident was out a star in the initial bound on the completed due to DON stated she was care was not completed always when it happerfor the first three weed wound care family not available, and the reassessed and measure Resident #15 was not nurse practitioner. To was not a wound care nursing staff had not wounds during the file Assigned nursing staff provide wound care replacement for the wassessment and measure on 11/4/21 at 2:05 p conducted with Resident a wound to his better the staff of the wassessment and measure on 11/4/21 at 2:05 p conducted with Resident a wound to his better the wound to his better the staff of the wassessment and measure of the wound to his better the wound the wound to his better the wound	empted with the facility nurse 21 and 11/5/21. Message ft, the mailbox was full. The hysician was informed on a message and no return call he facility nurse practitioner or man interview was foon and corporate nurse ff stated TAR documented if of the facility there would be a x and if there were no documented, the care was a insufficient staffing. The smade aware that wound ted as ordered, but not ened. The DON stated that each in October 2021 the curse practitioner was not sidents I wounds were not cured during this time. The DON stated that there are nown and assigned measured the resident I sets three weeks in October. The would be a sordered and there was no wound care practitioner I sets three weeks in October. The wound care practitioner I is assurement.	F	586			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		ATE SURVEY DMPLETED
		245400	B. WING			С
	ROVIDER OR SUPPLIER	345489 ITATION CENTER	b. WING	STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262		11/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 686	change his dressing, stated that he had no wheelchair was too s back which caused he resident stated the sushould be getting up backside.  On 11/4/21 at 2:05 prof Resident #15. He egg-crate mattress (foresident was large and a pressure reduction. The wheelchair apperesident 's width and.  The Administrator was jeopardy on 11/5/202.  On 11/6/2021 the factoredible allegation for removal that included. Allegation of Complia.  The facility failed to petto ensure residents residents residents residents residents residents residents administration removal that included antibiotic administration resident #6 was reactoric osteomyelitis and pressure ulcer. The was discharged to treatment of a declinion 10/18/2021. On 10/29 air mattress had malforeplaced. Resident #	"they missed some." He t gotten up because his mall, and he needed to lean im to be stuck in bed. The urgeon informed him he to relieve pressure on his man observation was done was in his bed with an coam mattress). The led filled the bed. There was cushion on the wheelchair. Lared to be too narrow for the had no option to lean back.  Is notified of the immediate 1 at 7:12 pm.  Illity provided an acceptable immediate jeopardy I the following:  Ince F 686 Pressure Ulcers  Incoince which resulted in ion, needed surgery, and on. (Residents #6 and #15). Idmitted with diagnosis:  In epilepsy, urinary retention TARS reveal scattered ments during the last month. The proposed in the hospital on 10/11/21 for ing wound and readmitted on 10/2021, it was noted that his	F 68	6		

0	OT OIT MEDIO/ ITE G					<u> </u>	<del>2. 0000 000 1</del>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			7. 50125			,	c
		345489	B. WING				10/2021
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	10/2021
					930 WEST SUGAR CREEK ROAD		
SATURN N	NURSING AND REHABIL	ITATION CENTER		l c	CHARLOTTE, NC 28262		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 686	Continued From page	<u> </u>	F	686			
	· ·	atment nurse and nurse	'	000			
		nt orders are to continue at					
		uation. Air mattress is					
		and checked every shift for					
		d resident is noted to be					
	comfortable during w						
	Resident #15 was ori						
		nosis: multiple sclerosis,					
		pressure ulcer. Wound was					
	noted on 9/22/2021 to	extend to the right ischial					
	area with identificatio	n of the right buttock which					
		nts ' wound records as a					
	Stage 4. Resident w						
	hospital for left sided						
		nile participating in therapy.					
		it was noted that resident '					
		eschar and wound was					
	_	nospitalization. Resident					
		0/28/2021 with new orders e initiated. Resident was					
		atment nurse and wound					
	•	11/05/2021. Resident was					
		no pain with treatment					
		s initiated and functioning					
	properly on 11/06/202	•					
	· · ·	has a total of ten (10)					
		s, as of 11/05/2021. The					
	Facility has employed	l a Full-Time wound Nurse					
	for the facility 11/5/20	21. The Corporate Clinical					
		ompetency with the facility					
		ector of Nursing to ensure					
		in wound identification,					
	measuring, treatment						
	The Director of Nursi						
	•	Head- to- toe assessment of					
		11/04/2021, to evaluate					
		and identify any new skin					
	_	as identified were cross					
	referenced with reside	ent ' s Treatment					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION	(X3) DATE COMP	SURVEY PLETED
		345489	B. WING				C 10/2021
	ROVIDER OR SUPPLIER			1930 W	T ADDRESS, CITY, STATE, ZIP CODE VEST SUGAR CREEK ROAD LOTTE, NC 28262	<u>, 117</u>	10/2021
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	Administration Recor in place and being im areas that would hav 's attending physicia and treatment order onew areas noted.  11/4/2021, Regional review of nurse 's noted on the previous weeks reviewed for current supdated as applicable updating resident car	d to ensure treatments were aplemented timely. Any new se been identified the resident in would have been notified obtained. There were no Clinical Nurse completed a stes, for the last 30 days. No noted. This included, an audit is ' wound progress notes, wound orders and were e. This also included e plans and care guides to for each resident to prevent	F	586			
	process or system fa Outcome from occurr the Action will be continued on 11/4/2021, all results were observed for fulfictor of nursing an Orders were added to by clinical nurses. The mattress ', on reside to be process of full body stays upon admission by 11/06/2021.  Director of Nursing/decurrent residents Braany risk for wound decurrent to the continued of th	idents with air mattresses nctioning equipment by the d administrative nurses. In the check function every shift here is currently eight (8) air					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG	_	(X3) DATE SURVEY COMPLETED
		345489	B. WING _			C 11/10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, 1930 WEST SUGAR CRE CHARLOTTE, NC 282	EEK ROAD	11/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)	
F 686	Continued From pag	ge 40	F	86		
		Verified completion was nal Clinical Nurse on				
	certified nursing ass certified nursing ass	designee re-educated istants, to include agency istance, on completing s, turning and repositioning sure by 11/06/2021.				
	including agency wil	facility nursing staff, I not be allowed to work until completed by Director of				
	will be provided this Director of Nursing/o orientation period.	nursing staff, including agency education by the facility designee during their The Director of Nursing and/or all new hires to include ior to working shift.				
	leadership changes it was identified that communication in exmanagement for prepressure ulcer programmers will be provided assure vigilance in Management Programmers and in facility will be provided assure vigilance.	over the past several months, the staff was lacking spectations for wound evention and treatment of am. Current Director of ded support and redirection in monitoring the Wound am. Current clinical leadership yided support and Regional Clinical Nurse.				
	Improvement (QAPI 11/6/2021. Director of correction to QAPI of	ssurance and Performance ) meeting will be held on of Nursing will present plan of ommittee for any approval mmendations (if any).				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION  NG	(X	(3) DATE SURVEY COMPLETED
		245400	B WING			С
	ROVIDER OR SUPPLIER	345489  LITATION CENTER	B. WING _	STREET ADDRESS, CITY, STATE, ZIP COE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	DE	11/10/2021
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	Effective 11/6/2021, Team (to include Dir Managers), will revie new admissions, dis hospital identified w wound MD progress administration record documented on the (5) x 's per week x t  Effective 11/6/2021, Director of Nursing to ensure implement correction for this all ensure the facility recompliance.  The immediate jeop The credible allegation 11/10/21.  An Ad-hoc Quality A Improvement (QAPI 11/6/2021.  Inservice education 11/7/2021 and 11/8/10 orientation.	the Nurse Management sector of Nursing, Unit sew in clinical morning meeting scharge summaries for any bunds, weekly skin audits, a notes and daily treatment ds. The audits will be Clinical Rounds Checklist five swelve (12) weeks.  the Administrator and will be ultimately responsible tation of this plan of leged noncompliance to	F 6	886		
	completed a review 30 days.  The Director of Nurs completing shower a	of nurse 's notes for the last sing provided education re: assessments, turning, and eviating pressure by				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C 11/10/2021
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		1171072021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	current licensed nurs the wound nurse was communicated to the to provide treatments physician.  Effective 11/6/2021, Team, to include Dire Managers, will review new admissions, disc hospital identified wo wound physician pro treatment administra  The Director of Nurs Nurses completed a current residents on  Most recent wound services were as foll  All residents observed for function  Director of all current residents identify any risk for w Assessments will con change in condition. 11/06/2021.  Staffing interviews w which included 12 ag staff. All staff verbal ulcer care and opera	eted re-education with less, including agency staff. If is not available, it would be elicensed nurses by the DON is as ordered by the  the Nurse Management ector of Nursing and Unit iv in clinical morning meeting charge summaries for any funds, weekly skin audits, igress notes, and daily tion records.  Ing and Administrative head- to- toe assessment of 11/04/2021.  Care note from physician bws:  Is with air mattresses were laing equipment.  Nursing/designee completed Braden assessment to	F 6	86		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C 11/10/2021	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		11/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 686	Continued From pa	ge 43	F 6	886			
F 725 SS=K	Sufficient Nursing S		F 7	725		12/10/21	
	the appropriate comprovide nursing and resident safety and practicable physical well-being of each resident assessment and considering the diagnoses of the fact accordance with the at §483.70(e).  §483.35(a)(1) The fact fact is sufficient number types of personnel conversing care to all resident care plans: (i) Except when wait this section, licensed (ii) Other nursing pelimited to nurse aide §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of this REQUIREMENT by:  Based on record resident interviews of the resident staff, the fact is sufficient in the fact in the sufficient in the fact in the sufficient in the suffici	ve sufficient nursing staff with petencies and skills sets to related services to assure attain or maintain the highest and mental, and psychosocial esident, as determined by ts and individual plans of care number, acuity and sility's resident population in facility assessment required acility must provide services as of each of the following on a 24-hour basis to provide esidents in accordance with eved under paragraph (e) of dinurses; and resonnel, including but not is section, the facility must dinurse to serve as a charge		F 725 Sufficient Nursing St # 1 - Address how correctiv accomplished for those resi	e action will be		

PRINTED: 12/14/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		345489	B. WING			C <b>I1/10/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	2.2.22	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		11/10/2021
	10 115211 011 001 1 21211			1930 WEST SUGAR CREEK ROAD		
SATURN N	IURSING AND REHABIL	ITATION CENTER		CHARLOTTE, NC 28262		
				CHARLOTTE, NC 28282		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 725	Continued From page	e 44	F 7	25		
		ressure ulcer wound care as		have been affected by the de	eficient	
	ordered and pressure sampled residents (#	e ulcer prevention, for 2 of 3		practice:		
		errors for 3 of 3 sampled		Director of Nursing and Corp	oorate Nurse	
	_	r medication administration		Consultant completed a revi		
		and 3.) Provide activities of		medical record for Resident		
		ent dependent on staff for		#14, #6, and #15, to ensure	•	
	residents (#6).	shing for 1 of 3 sampled		outcomes due to missed me and/or treatments. The atter		
				physician for these residents	-	
		began on 9/22/21 when		by the DON and RCN of the		
		staff to carry out wound		medications and/or treatmen		
		ents #6 and 15 who both had		10/29/21. Attending Physicial current medication and/or tree		
	_	their wounds. The facility icient staffing to complete		ordered, and no new orders		
	resident ordered wou	- · · · · · · · · · · · · · · · · · · ·		obtained Residents #12, #1		
	reduction for pressure			and #15 have been receiving		
		was removed on 11/7/2021		medications and/or treatmen	nts as ordered	
	when the facility imple			by their attending physician		
	_	te Jeopardy removal. The		12/10/21. The director of nu		
	_	of compliance at a lower vel of E (no actual harm with		schedule, and Corporate Nu Consultant reviewed current		
		Il harm that is not Immediate		schedule to ensure staffing v	•	
	•	indings 2. and 3. and to		for resident census. This wa		
		systems are put in place		11/6/21	·	
	and to complete emp	loyee in-service.				
				# - 2 Address how the facility	•	
	Findings included:			other residents having the po		
	1. Cross refer to F686	).		affected by the same deficie	nt practice:	
	Based on record revie			Any Residents had the poter		
		ent, staff, guardian, Wound		affected by the alleged defic	ient practice.	
		oner and physician, the		The Composite Officiant N		
	_	ss and document wounds		The Corporate Clinical Nurse the Director of Nursing, and	•	
	consistently; provide ordered; and provide			completed a master schedul		
		ted in accordance with		11/6/21, that will ensure prop		
		uctions. These failures led		levels, including RN coverage	•	
		f new wounds, wounds that		for 7 days/week, based on o		

Facility ID: 923538

		E SURVEY IPLETED				
		345489	B. WING			C
NAME OF DE	ROVIDER OR SUPPLIER	343409	B: Willo _	CTREET ADDRESS CITY STATE 7ID.		1/10/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
SATURN N	IURSING AND REHABIL	ITATION CENTER		1930 WEST SUGAR CREEK ROAD		
				CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 725	Continued From page	e 45	F 7	25		
	worsened in size and #15), and wounds that interventions. These sampled residents with Resident #6 developed the elbow, developed and sacrum that because worsened to the sacrum that because with the sacrum that the sac	became infected (#6 and at resulted in hospital problems affected 2 of 3		resident census to ensure care, including wound care nail/hair care) and medica provided timely.  # -3 Address what measure into place or systemic characterists.	e, ADL (bathing, tions are res will be put nges made to	
	of the osteomyelitis w Resident #15 develop advanced to the high	relief while in bed. hospitalization for treatment with intravenous antibiotics. bed a new wound that est stage with infection. cal debridement and hospital		recur:  The Director of Nursing, S Coordinator, and Executiv re-educated by the Clinica Consultant on ensuring pr coverage, including Regis coverage 8 hours/day, 7 d	e Director were Il Nurse oper staff tered Nurse	
	staff call out, they we Director of Nursing. Survive nursing staff had bee months and the facilitiem ployee nursing as has had to use agency staffing agencies to fi and nursing assistant short NA staff, and had open on first shift, 2-3 and 3 shifts open on would contact the staff advance to schedule. When there were no staff would have to taff assignment. She staff a day to help fill in as stated that she had not staff would have to the staff and the staff would have to the staff would have to the staff would have to the staff would have the staff w			based on current facility or resident care, including wo (bathing, nail/hair care) an are provided timely. This completed on 12/10/21. Director of Nursing, unit m regional nurse consultant re-training with licensed numedication aides, certified assistants on the need to residents receive grooming bathing, assistance with m treatments, and medicatio training will be completed Any nursing employee, inc who does not receive this 12/10/21, will not be able to training is completed. Director of Nursing has co re-education with current I Nurses, including Agency wound nurse is not available.	ensus, to ensure bund care, ADL and medications re-training was enanagers and are providing urses, I nursing ensure all g, nail care, neals, ns timely. This by 12/10/21. Cluding agency training by to work until empleted Licensed staff, If the	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 55.2515	·	С	
		345489	B. WING		11/10/2021	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	111/10/2021	
				1930 WEST SUGAR CREEK ROAD		
SATURN N	IURSING AND REHABIL	ITATION CENTER		CHARLOTTE, NC 28262		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		NC
F 725	Continued From page	<del>2</del> 46	F 72	5		
		s about 30 residents and		the Director of Nursing to provide		
		t each for their shift. This		treatments as ordered by the phys	ician. If	
	type of assignment ap	oplied to all shifts.		the licensed nurse cannot comple	te the	
				treatments within the parameter or		
		ew was conducted with the		work schedule, the licensed nurse		
		ated that she was working		report the issue to the Director of	_	
	_	Iditional staffing agencies to		and/or facility Executive Director.		
	address the facility 's			Director of Nursing and/or Unit Ma	nager	
	problem. There was			will complete the assessment and		
		contracted agency staff		measurements. This training will be		
		requently did not show up for		completed as of 11/6/21, any curre		
	their assignment. Part of the new contract plan was for the agency to hold staff accountable			nurse, including agency, who is un receive this training will not be allo		
		w and to give adequate		work until training is completed by		
	notice when staff can	- ·		Director of Nursing and/or designed		
	nouse when stan san	not work.		Licensed Nursing staff, including a		
	The Administrator wa	s notified of the immediate		will receive this training at time of		
	jeopardy on 11/5/202	1 at 7:12 pm.		orientation. Anyone who has not b	een	
				educated by 12/10/2021 will no be		
		lity provided an acceptable		to work until training has been cor	npleted.	
	credible allegation for					
	removal that included	the following.		# 4 - Indicate how the facility plans		
				monitor its performance to make s	ure that	
		nts who have suffered, or		solutions are sustained;		
	_	serious adverse outcome		The facility Director of Nursing an	1	
	because of the nonco	ппрпапсе.		The facility Director of Nursing and Human Resources has re-implem		
	The facility failed to n	rovide sufficient nursing staff		recruiting initiative program begini		
		ceived consistent pressure		10/30/21 & 11/1/21, for licensed n		
		rdered which resulted in		Certified Medication Aides (CMAs	·	
		on, needed surgery, and		Certified Nursing Assistants (CNA		
		on. (Residents #6 and		includes utilizing Agency Supplem		
	#15).	•		Staffing to maintain appropriate st		
	,			numbers, implementing a bonus p	•	
	All Residents had the	potential to be affected by		for full-time and referral bonus' for		
	the alleged deficient p	· ·		current licensed nurses, as well as		
				sign-on bonus for new employees		
	The Facility currently	has a total of ten (10)		Executive Director will implement	a daily	
	residents with wound	s, as of 11/5/21. The		labor meeting that will include, Dir	ector of	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
			71. 501251	_			c
		345489	B. WING				/10/2021
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	930 WEST SUGAR CREEK ROAD		
SAIURNI	NURSING AND REHABIL	LITATION CENTER		С	HARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	for the facility 11/5/2′ Nurse completed a C wound nurse & Director were competent in w measuring, treatmen  The Director of Nursi Nurses completed a current residents on current skin condition deficiencies. Any are referenced with resid Administration Recor in place and being in areas that would hav 's attending physicia and a treatment ordenew areas noted.  The facility Director of Resources has re-iminitiative program beging for licensed nurses, (CMAs), Certified Nuincludes utilizing Age maintain appropriate implementing a bonureferral bonus ' for thas well as sign-on both The facility governing Director made the deadmissions to ensure staffing and regulator	d a Full-Time wound Nurse  I. The Corporate Clinical competency with the facility stor of Nursing to ensure they ound identification, ts and healing.  Ing and/or Administrative Head-to-Toe assessment of 11/4/2021, to evaluate and identify any new skin eas identified were crossistent is Treatment and to ensure treatments were aplemented timely. Any new to been identified the resident in would have been notified ar obtained. There were notified ar obtained. There were no of Nursing and Human plemented a recruiting ginning 10/30/21 & 11/1/21, Certified Medication Aides raing Assistants (CNA), this ency Supplemental Staffing to staffing numbers, is program for full-time and neir current licensed nurses, onus for new employees. It is body along with Regional ecision, 9/27/21, to stop new encountered to stability stability of current	F	725	Nursing (DON), Staffing Coordinator, Human Resources, and other member the Leadership Team, to review curren daily staffing needs and forecast the remaining week, including weekends to ensure sufficient staff is available for the resident needs, to include medication administration and wound care, in the facility. This meeting began 11/5/21. A identified need for staff, the executive director will authorize, overtime/bonus for current staff to fill open positions and/or authorize agency usage from the facility contracted staffing to ensure the facility has staffing to provide current resident care, including resident care, including wound care, ADL (bathing, nail/hair care) and medications are provided timely.  The Director of Nursing and/or Execution Director will monitor staffing five times week during the daily Stand-up/clinical meeting. The Director of Nursing and/or designee will monitor the staffing daily days per week to ensure that all callour are reported timely, and coverage is available to include a Registered Nurse for 8 hours 7 days per week.  The Executive Director will complete a summary of monitoring efforts and present at the monthly Quality Assuran and performance Improvement meeting to ensure continued compliance  # 5 - Completion date: 12/10/2021	t  D  D  D  D  D  D  D  D  D  D  D  D  D	
	Aides to assist with N	utilizing Certified Medication  Medication Administration  a Licensed Nurse, to allow					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345489	B. WING			C 11/10/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		11/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 725	Licensed Nursing sta assessments and tre has been having con nurses about the exp be completed by 11/6 Specify the Action the process or system fa	aff more time to perform atments. Director of Nursing versations with the licensed pectations of the program to 6/21.  The Facility will take to alter the ilure to Prevent a Serious	F 7	725			
	the Action will be con  Executive Director w meeting that will inclu (DON), Staffing Coor and other members of review current daily s the remaining week, ensure sufficient staff needs, to include wo meeting began 11/5/. The Corporate Clinic Director of Nursing, a completed a master s will ensure proper star resident census to en treatments are comp	ill implement a daily labor ude, Director of Nursing dinator, Human Resources, of the Leadership Team, to staffing needs and forecast including weekends to f is available for the resident und care, in the facility. This 21.  al Nurse along with the and Scheduler, has schedule, as of 11/6/21, that affing levels based on current insure that resident wound leted timely.					
	with current Licensed staff, If the wound not communicated to the Director of Nursing to ordered by the physicannot complete the parameter of their wonurse will report the in Nursing and/or facilit Director of Nursing a	as completed re-education d Nurses, including Agency arse is not available, it will be elicensed nurses by the o provide treatments as cian. If the licensed nurse treatments within the ork schedule, the licensed ssue to the Director of y Executive Director. The and/or Unit Manager will ment and measurements.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED		
		345489	B. WING _			C 11/10/2021		
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	ODE	11/10/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF  X (EACH CORRECTIVE ACT  CROSS-REFERENCED TO T  DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 725	This training will be or current nurse, includir receive this training wantil training is completed with the process of the Director of Nursing ensure treatments are is completed. The Corcompleting observation with the facility clinical training regarding worteratments.  The Director of Nursing Administrator will more during the daily Stand of nursing and/or desstaffing daily 7 days process call-outs are reported available.  The Facility Administrator will more during the daily Stand of nursing and/or desstaffing daily 7 days process call-outs are reported available.  The Facility Administrator monthly Quality Assulf Improvement meeting compliance  The facility alleges the Jeopardy on Nov 7, 2	ompleted as of 11/6/21, any agency, who is unable to rill not be allowed to work eted by the Director of nee. New Licensed Nursing y, will receive this training at the control of the example of the exa	F7	725				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345489	B. WING_			C 1/10/2021	
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	•	11/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 725	Human Relations Defair at the facility which medication aide and a Machoc Quality As Improvement (QAPI) 11/6/2021.  The Executive Direct meeting. The first meaddressed staffing not Sunday. An 11/8/21 rahead and open nurse noted 2 new staff memedication aide and The Corporate Clinical and scheduler had coas of 11/6/21 that wo levels based on currest that resident wound to completed as ordered The Director of Nursi re-education with cur including agency staff Resident wound treat by weekly observation.	prate Recruiter and facility partment completed a job ch resulted in 2 new hires, a a nurse.  Issurance and Performance meeting was held on  or implemented a daily labor reting was on 11/5/21 and it reds for Friday through meeting discussed the week sing spots and the 11/9/21 mbers in orientation, 1 nurse for night shift.  All Nurse along with the DON ompleted a master schedule and ensure proper staffing rent resident census to ensure reatments would be did.  Ing had completed rent licensed nurses, if was documented. It was a documented and and or Facility onitored staffing 5 times a stand-up meeting.	F 7	25			
	<ul><li>11/7/21.</li><li>2. Cross refer to F</li></ul>	760.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING				C 10/2021
	ROVIDER OR SUPPLIER	ITATION CENTER	-1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	staff and Medical Door prevent significant me scheduled doses of a atrial fibrillation (Resicheck blood glucose scale aspart insulin (a medication) was need doses of detemir (a lowedication) (Resident blood glucose levels doses of aspart beford doses of detemir (Residents reviewed for a separation of the separation o	ew and interviews with the ctor the facility failed to edication errors by omitting medication used to treat dent #14) and failed to levels to determine if sliding a fast-acting antidiabetic ded and omitted scheduled ong-acting antidiabetic tr #12) and failed to check and omitted scheduled e meals and scheduled e meals and scheduled sident #13) for 3 of 3 r medication errors.  677.  ew, observation, and and staff, the facility failed to do nail care to a dependent of for 1 of 3 residents  Full Time DON-(3)  d nurse  when waived under of this section, the facility is of a registered nurse for at ours a day, 7 days a week.  when waived under of this section, the facility is section of the facility is section, the facility is section, the facility is section, the facility is section of the facility is section.		725			12/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345489	B. WING		C 11/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/10/2021	
				1930 WEST SUGAR CREEK ROAD		
SATURN N	NURSING AND REHABIL	ITATION CENTER		CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 727	Continued From page	e 52	F 72	7		
	This REQUIREMENT by:	is not met as evidenced				
	Based on record review and interviews with staff, the facility failed to have a Registered Nurse (RN) 8 hours a day for 7 days a week for 3 of 6 days			F 727 – RN 8 Hrs/7 days/Wk, Full Tir DON:	me	
		10/25/21, 10/26/21, and		# 1 - Address how corrective action was accomplished for those residents four have been affected by the deficient practice:		
	The findings included	:		Director of Nursing and Corporate Nu	rse	
	10/25/21 and 10/26/2	affing hours revealed on 1 the census was 92 with no 10/28/21 the census was 91 urs.		Consultant completed a review of the medical record for Resident #12, #13 #14, #6, and #15, to ensure no negat outcomes due to missed medication and/or treatments. The attending physician for these residents were no	ive	
	PM with the Staffing 0 confirmed she had no RN each day for 8 ho revealed she currentl	ducted on 10/28/21 at 1:05 Coordinator (SC). The SC of been able to schedule an urs 7 days a week. The SC y worked with 4 staffing of to meet the needs of		by the DON and RCN of the missed medications and/or treatments, on 10/29/21. Attending Physician contin current medication and/or treatments ordered, and no new orders were obtained Residents #12, #13, #14, # and #15 have been receiving their medications and/or treatments as ord by their attending physician as of 12/10/21.	as 6	
	Director of Nursing re times no RN was sch and stated it had bee available to work. The	n 10/29/21 at 4:38 PM the evealed there had been eduled for 8 hours a day n difficult to find RNs e DON revealed she was not ours but had worked 12		The director of nursing, schedule, and Corporate Nurse Consultant reviewed current staffing schedule was adjuste 11/6/21, to ensure Registered Nurse coverage, 8 hours/day; 7 days/week, in place, to provide supervision.  # - 2 Address how the facility will iden other residents having the potential to affected by the deficient practice: Any Residents had the potential to be	d on (RN) was tify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345489	B. WING			C / <b>10/2021</b>	
NAME OF P	ROVIDER OR SUPPLIER		' I	STREET ADDRESS, CITY, STATE, ZIP CODE		10,2021	
CATUDNI	JUDGING AND DELIABIL	ITATION CENTED		1930 WEST SUGAR CREEK ROAD			
SAIUKNI	NURSING AND REHABIL	HATION CENTER		CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 727	Continued From page	e 53	F 7:	affected by the alleged deficient practice of Nursing, and Schedic completed a master schedule, as on 11/6/21, that will ensure proper stafflevels, including RN coverage 8 hor for 7 days/week, based on current resident census to ensure that resident census to ensure that resident care, including wound care, ADL (binail/hair care) and medications are provided timely.  # -3 Address what measures will be into place or systemic changes may ensure that the deficient practice with recur;  The Director of Nursing, Staffing Coordinator, and Executive Directore-educated by the Clinical Nurse Consultant on ensuring proper staff coverage, including Registered Nurcoverage 8 hours/day, 7 days/week based on current facility census, to resident care, including wound care (bathing, nail/hair care) and medicate provided timely. This re-training completed on 12/10/21.  Director of Nursing, unit managers regional nurse consultant are provider-training with licensed nurses, medication aides, certified nursing assistants on the need to ensure all residents receive grooming, nail cabathing, assistance with meals, treatments, and medications timely training will be completed by 12/10/Any nursing employee, including against to the completed by 12/10/Any nursing employee, including against and medications timely training will be completed by 12/10/Any nursing employee, including against and medications timely training will be completed by 12/10/Any nursing employee, including against and medications timely training will be completed by 12/10/Any nursing employee, including against and medications timely training will be completed by 12/10/Any nursing employee, including against and the surface and the surf	with uler, f f fing urs/day dent athing, e put de to ill not r were se se, ADL tions g was and ding l re, . This 21.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345489	B. WING			С
		345489	B. WING _			11/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Æ	
SATURNI	NURSING AND REHABIL	ITATION CENTER		1930 WEST SUGAR CREEK ROAD		
0,1101111	1011011107111011121171211			CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	DATE
F 727	Continued From page	e 54	F 7	who does not receive this traing 12/10/21, will not be able to we training is completed. Director of Nursing has compree-education with current Lice Nurses, including Agency star wound nurse is not available, communicated to the licensed the Director of Nursing to provide treatments as ordered by the the licensed nurse cannot contreatments within the parame work schedule, the licensed report the issue to the Director and/or facility Executive Director of Nursing and/or Unwill complete the assessment measurements. This training completed as of 11/6/21, any nurse, including agency, who receive this training will not be work until training is completed.  Will receive this training at time orientation. Anyone who has educated by 12/10/2021 will reallowed to work until training completed.  # - 4 Indicate how the facility monitor its performance to massolutions are sustained; and I when corrective action will be the facility Director of Nursing Human Resources has re-imprecruiting initiative program be 10/30/21 & 11/1/21, for licens	work until eleted ensed ff, If the it will be d nurses by vide physician. mplete the ter of their nurse will or of Nursir ctor. The nit Manage t and will be current is unable e allowed the ed by the signee. No ding agence the of their not been not be has been  plans to ake sure the linclude dat e completed g and plemented eginning	r to to ew y,  nat tes d:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345489	B. WING			441	
NAME OF D	ROVIDER OR SUPPLIER	343403	1 5: ******	STREET ADDRESS, CITY, STATE, ZIP COD		11/	10/2021
NAIVIE OF F	KOVIDER OR SUFFLIER						
SATURN I	NURSING AND REHABIL	ITATION CENTER		1930 WEST SUGAR CREEK ROAD			
				CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE		(X5) COMPLETION DATE
F 727	Continued From page	e 55	F7	Certified Medication Aides (CI Certified Nursing Assistants (Gincludes utilizing Agency Supp Staffing to maintain appropriar numbers, implementing a bon for full-time and referral bonus current licensed nurses, as we sign-on bonus for new employ Executive Director will implem labor meeting that will include Nursing (DON), Staffing Coord Human Resources, and other the Leadership Team, to revie daily staffing needs and forecaremaining week, including we ensure sufficient staff is availar resident needs, to include me administration and wound carfacility. This meeting began 1' identified need for staff, the exidirector will authorize, overtim for current staff to fill open post and/or authorize agency usag facility contracted staffing to efacility has staffing to provide resident care, including reside including wound care, ADL (binail/hair care) and medication provided timely.  The Director of Nursing and/o Director will monitor staffing films week during the daily Stand-umeeting. The Director of Nursing and/o Director will monitor the staff days per week to ensure that are reported timely, and cover available to include a Register for 8 hours 7 days per week.  The Executive Director will control of the staff to the staff	CNA), this plemental te staffing hus progras is for their ell as yees. The plement a dail of the plement a dail of the plement as the ekends to able for the dication re, in the 1/5/21. A executive resistions per from the current ent care, athing, is are or Executive times a plement and call of the plement and care, athing, is are or Executive times a plement and call callout rage is red Nurse the executive and call callout rage is red Nurse	ly of sof to e ny pay e e e e e e e e e e e e e e e e e e e	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
				_		(	C
		345489	B. WING _			11/	10/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHONIA	URSING AND REHABIL	TATION CENTER		19	930 WEST SUGAR CREEK ROAD		
SAIUKNI	IURSING AND REHABIL	HAHON CENTER		С	HARLOTTE, NC 28262		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 727	Continued From page	- 56	F	727			
					summary of monitoring efforts and present at the monthly Quality Assuran and performance Improvement meeting to ensure continued compliance.		
					# 5 - Completion date: 12/10/2021		
F 760 SS=E	Residents are Free of CFR(s): 483.45(f)(2)	Significant Med Errors	F	760			12/10/21
	medication errors.	re that its- its are free of any significant is not met as evidenced					
	Based on record revi staff and Medical Doo	ew and interviews with the tor the facility failed to edication errors by omitting			F760 – Resident are Free of Significar Med Errors:	nt	
	scheduled doses of a atrial fibrillation (Resid check blood glucose I scale aspart insulin (a	medication used to treat dent #14) and failed to evels to determine if sliding fast-acting antidiabetic			# 1 - Address how corrective action will accomplished for those residents found have been affected by the deficient practice:	d to	
	doses of detemir (a lo medication) (Residen	led and omitted scheduled ng-acting antidiabetic t #12) and failed to check and omitted scheduled			Resident #14- no longer is at the facility Director of Nursing and Corporate Nurs Consultant completed a review of the medical record for Resident #12, #13,	•	
		e meals and scheduled sident #13) for 3 of 3			#14, #6, and #15, to ensure no negative outcomes due to missed medication and/or treatments. The attending	е	
	The findings included				physician for these residents were notified by the DON and RCN of the missed medications and/or treatments, on 10/29/21. Attending Physician continued	ed	
	2/10/21 with diagnose	•			current medication and/or treatments a ordered, and no new orders were obtained Residents #12, #13, #14, #6 and #15 have been receiving their medications and/or treatments as order by their attending physician as of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345489	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER	0.0.00	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>  11/</u>	10/2021
IVAIVIL OI II	TOVIDER OR GOLT EIER				930 WEST SUGAR CREEK ROAD		
SATURN N	NURSING AND REHABIL	ITATION CENTER			HARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page	e 57	F 7	'60	12/10/21.		
	revealed Resident #1 for acute respiratory of a new onset of atrial theartbeat) but was not anticoagulation (med blood) therapy. The of the plan was to continuous for acute the plan was to continuous for acute #1	ications used to thin the lischarge summary revealed			# - 2 Address how the facility will identification other residents having the potential to affected by the same deficient practice Complete Audit for all current resident' Medication/treatment administration records was completed by Director of Nursing and Regional Clinical Nurse to ensure and to identify any other reside medications/treatments that were miss on 10/10/2021 and 10/24/2021. If there were any other omissions identified the	be : s nts' ed	
		nt change Minimum Data Set 1 assessed Resident #14's ely impaired.			resident's attending physician was noti on 10/28/21. Facility Social Worker and Administrati Leadership completed interviews with current interviewable residents to ensu they have no identified concerns with	ve	
	cardiovascular disease fibrillation, congestive hypertension with the not experience comp disease through the r	vised on 10/12/21 identified se diagnoses as being atrial e heart failure, and e goal Resident #14 would lications of cardiovascular next review. Interventions ardiac medications as			receiving their medication timely. Thes interviews will be completed by 12/10/2 Any identified concerns will be taken through the facility Grievance process the Social Worker and Executive Direct # -3 Address what measures will be purint place or systemic changes made to ensure that the deficient practice will neceur:	21. by tor. t	
	revealed on 10/10 an	d (MAR) for October 2021 d 10/24 the letter N stered) was documented ion of diltiazem 120 at 8:00 AM.			The director of nursing and/or unit managers will be reviewing current resident medication/treatment records, previous 24 hours, at the Clinical AM meeting, to ensure to ensure that residents are receiving their medication/treatments as ordered by the attending physician. If there are any noted omissions, the licensed nurse wi	neir	
	10/25/21 Resident #1	4 received the scheduled			be contacted for re-education, verificat		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			1	C <b>10/2021</b>	
NAME OF PE	ROVIDER OR SUPPLIER	2.5.55	_ <del> </del>	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	10/2021	
	10 115211 011 001 1 2.2.1				330 WEST SUGAR CREEK ROAD			
SATURN N	IURSING AND REHABIL	ITATION CENTER			HARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 760	Continued From page	e 58	F 7	760				
	dose of diltiazem at 8 pressure reading of 1				that medication/treatment was administered, and completion of documentation. On 11/04/2021, Director of Nursing			
	PM with Nurse #1. No 10/10/21 and 10/24/2	1 she worked by herself on			received 1:1 education by Corporate Clinical Nurse to ensure that enough nurses are in the facility to administer			
	only nurse till after 3 l revealed she was una	assignment and was the PM on both days. Nurse #1 able to administer all ts on the second nurse			medication per MD orders. Expectation if there is no one to take the medication cart the expectation is the Director of Nursing and/or Unit Manager will come	า		
	Director of Nursing (E	1 revealed she notified the DON) there was no nurse medication administration			the facility to administer medication(s). Director of Nursing and/or Regional Clinical Nurse completed re-education			
		assignment on 10/10/21 and fter 3:00 PM before a to help.			with licensed nurses, medication aides including agency, related to timely documentation of medication/treatmen administration records. This included, notification of the Medical Director,			
	Doctor (MD) on 11/4/2	ducted with the Medical 21 at 9:43 AM. The MD ed diltiazem a significant			Director of Nursing and Executive Dire if medication or treatments were not completed timely. Any licensed nurse			
	newly diagnosed with candidate for anticoag	aware Resident #14 was atrial fibrillation and not a gulant medications. The MD er shift could see daily the			including agency who has not received this education by 12/10/21, they will no able to work until education completed	t be		
	medication was not a given the diltiazem.	dministered and could have			# - 4 Indicate how the facility plans to monitor its performance to make sure t solutions are sustained; and Include da when corrective action will be complete	ates		
		admitted to the facility on ses of type 2 diabetes a.			The director of nursing and/or unit managers will be reviewing current resident medication/treatment records, previous 24 hours, at the facility clinica AM meeting, 5 x week for 4 weeks, the	I		
	assessed Resident # severely impaired. The	rly MDS dated 8/20/21 12's cognition as being ne MDS medication review tions were given 7 days			3 x week for 4 weeks, to ensure that residents are receiving their medication/treatments as ordered by thattending physician.	neir		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING				C 40/2024	
NAME OF PI	ROVIDER OR SUPPLIER	J-0-103	5	S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	10/2021	
SATURN N	NURSING AND REHABIL	LITATION CENTER			930 WEST SUGAR CREEK ROAD HARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)			(X5) COMPLETION DATE	
F 760	Continued From pag	e 59	F	760				
	diabetes mellitus and levels with the goal FA1C (a percentage of over a period of 3 modern of 1 modern	vised on 5/9/21 identified duncontrolled blood sugar Resident #12 would have an if blood glucose readings onths) be below 6. d administer hypoglycemic good glucose levels as orders for insulin revealed receive aspart inject sliding scale started on inject 30 units y morning started on 6/24/21			The director of nursing will complete a summary of these audit results and present at the monthly Quality Assuran Performance Improvement meeting, to ensure continued compliance.  # 5 - Completion date: 12/10/2021			
	10/10/21 the letter N times of 7:30 AM and administration of slid no blood glucose real scheduled blood gluc #12 was done on 10/ of 301 and 6 units of per sliding scale of 3 also documented und deterministration inject scheduled at 8:00 AM A second review of Fon 10/24/21 the letter	rd (MAR) revealed on was documented for the did 11:30 AM under the ing scale aspart insulin with indings documented. The next cose reading for Resident (10/21 at 4:30 PM with a level aspart insulin was provided 01 to 350. The letter N was der the administration of 30 units subcutaneously						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C 11/10/	/2021	
NAME OF PROVIDER OR SUPPLIER  SATURN NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		11710	72021	
(X4) ID PREFIX TAG			ID PREFI) TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 760	no blood glucose read scheduled blood gluc #12 was done at 4:30 4 units of aspart insul scale of 251 to 300. T documented under the insulin inject 30 units at 8:00 AM.  An interview was con PM with Nurse #1. No	ng scale aspart insulin with dings documented. The next ose reading for Resident PM with a level of 260 and in was provided per sliding he letter N was also e administration of detemir subcutaneously scheduled ducted on 10/28/21 at 5:25 urse #1 revealed on	F	760				
	a unit with a 2-nurse a only nurse till approxi Nurse #1 revealed shall medications to resussignment and had a readings or administer revealed she notified (DON) there was no redication administrations assignment on 10/10/	1 she worked by herself on assignment and was the mately 3 PM on both days. e was unable to administer idents on the second nurse not checked blood glucose ared insulin. Nurse #1 the Director of Nursing nurse assigned to complete ation for the second nurse /21 and 10/24/21 and it was a second nurse arrived to						
	AM with the MD. The levels needed to be n administration of insu blood glucose levels to doses were missed h medication error for a physician orders to be	or DON to contact him or						

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345489	B. WING		C 11/10/2021
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262	11/10/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		ULD BE COMPLETION
F 760	Continued From pa		F 76	50	
	4/9/19 with diagnos	s admitted to the facility on sees of type 2 diabetes mellitus ction pulmonary disease.			
	Review of physician orders for insulin revealed Resident #13 was to receive aspart inject 25 units subcutaneously before meals started on 6/29/21 and detemir inject 30 units subcutaneously twice a day started on 5/27/21 for diabetes mellitus.  Review of the quarterly MDS dated 8/24/21 assessed Resident #13's cognition as being intact. The medication review of the MDS revealed insulin injections were administered for 7 days during the assessment period.				
	risk related to the c with the goal Resid hypo and/or hyperc	reviewed on 9/6/21 identified diagnosis of diabetes mellitus lent #13 would not experience glycemia through the next as included administer insulin			
	10/10/21 the letter administration of in scheduled at 7:30 Aunder the 11:30 Aunder the 11:3	or Resident #13 revealed on N was documented under the sulin aspart inject 25 units AM and no documentation M administration time. The next insulin aspart was 80 PM. The letter N was also the insulin detemir inject 30 8:00 AM with no blood glucose ed. The next scheduled dose of administered at 8:00 PM with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345489	B. WING _			C 1/10/2021		
NAME OF PROVIDER OR SUPPLIER  SATURN NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262		1/10/2021		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		SHOULD BE	(X5) COMPLETION DATE		
F 760	revealed on 10/24/21 documented under the	ing of 214. ne MAR for Resident #13	F 7	60				
	11:30 AM. The next sadministered at 4:30 documented under the of insulin detemir. The	scheduled dose was PM. The letter N was also ne scheduled 8:00 AM dose						
	An interview was conducted on 10/28/21 at 5:25 PM with Nurse #1. Nurse #1 revealed on 10/10/21 and 10/24/21 she worked by herself on a unit with a 2-nurse assignment and was the only nurse till approximately 3 to 4 PM on both days. Nurse #1 revealed she was unable to administer all medications to residents on the second nurse assignment and had not checked blood glucose readings or administered insulin. Nurse #1 revealed she notified the Director of Nursing (DON) there was no nurse assigned to complete medication administration for the second nurse assignment on 10/10/21 and 10/24/21 and it was after 3:00 PM before a second nurse arrived to help.							
	AM with the MD. The levels needed to be radministration of insublood glucose levels doses were missed h	ducted on 11/4/21 at 10:32 MD revealed blood glucose monitored closely for the ulin. The MD revealed if were not taken, and insulin the considered as a significant the MD expected physician						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _				C 10/2021
NAME OF PROVIDER OR SUPPLIER  SATURN NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	DE		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	TION SHOULD BE THE APPROPRIATE		(X5) COMPLETION DATE
F 760		e 63 I, and when missed, for the tact him or the Nurse	F 7	60			
	Director of Nursing (I unaware residents di medications on 10/10 revealed she was no on to cover an assignexplained typically if covered, she came in town. On 10/24/21 thaware there was not assignment on the unwith the number of rewould not expect one medication administriberself. The DON revetown on 10/24/21 but	on 10/29/21 at 4:30 PM the DON) revealed she was do not receive their scheduled 0/21 or 10/24/21. The DON to aware there was no nurse ment on 10/10/21 and a nurse shift was not in to cover but was out of the DON revealed she was a nurse to cover the second with the nurse was a nurse to cover the second with the nurse ould complete a cation for all the residents by wealed she was also out of the tenth to the tenth to the nurse was also out of the tenth to the nurse was also out of the the nurse could complete a cation for all the residents by wealed she was also out of the the nurse was also out of the the nurse could she was also out of the nurse was also was also out of the nurse was also out of the nurse was also out of the nurse was also was also out of the nurse was also w					
	Interim Administrator made aware residen medications on 10/10 explained the facility staff shortages, but a shortage specifically their medications. The Interdisciplinary Tear no discussion about their medications on because a lack of nur	20/21 and 10/24/21. The IA continued to have nursing she did not know the related to residents missing the IA revealed during their in Meetings there had been residents who did not receive 10/10/21 and 10/24/21 rse staff to administer tated on the dates there was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345489	B. WING		C 11/10/2021
	NAME OF PROVIDER OR SUPPLIER  SATURN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262	11110/2021
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO		D BE COMPLETION
F 760	should inform their s medications were no DON to notify her.	or of command and the nurse superior or the DON if of given and would expect the	F 70		12/10/21
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary		F 8	F-812 Food Storage  # 1 - Address how corrective action accomplished for those residents fo have been affected by the deficient practice: No Resident was named. Food Service Manager discarded unlabeled, undated items from the nourishment rooms (South, North, No	und to

PRINTED: 12/14/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
		345489	B. WING			C
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	•	11/10/2021
NAME OF T	TOVIDER OR SOLT LIER			, , ,	CODE	
SATURN N	IURSING AND REHABIL	ITATION CENTER		1930 WEST SUGAR CREEK ROAD		
				CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 812	Continued From page	e 65	F 8	12		
		M), observations were made ated fast-food shake, an		on 10/29/21.		
		rink, and an unlabeled water		# - 2 Address how the fac	ility will identify	
		and nutritional supplement in		other residents having the		
		ed, unlabeled container of		affected by the same defic		
		erved in the refrigerator. An		Any resident had the pote		
	unlabeled, undated lu	ınch bag containing an		affected.		
	additional 3 unlabeled, undated plastic-wear			Food Service Manager did	d complete	
	containers were also	observed in the refrigerator.		observation rounds to ens		
	During a tour of the North Hall nourishment room on 10/28/2021 at 4:31 PM with the interim FSM,			any other items, unlabeled		
		e of an opened, unlabeled		10/23/21		
		frigerator and an unlabeled		# -3 Address what measu	res will be put	
	slab of spareribs in th	_		into place or systemic cha	•	
	·			ensure that the deficient p	-	
	During a tour of the V	Vest Hall nourishment room		recur.		
	on 10/28/2021 at 4:38	B PM with the interim FSM,		Facility Nourishment room	s will be	
	observations were ma			stocked daily by dietary de	•	
	unlabeled bag of chic	ken strips, and an unlabeled		open items, should be lab	eled, dated, and	
	container of ice crean			resident name (if applicab		
		unlabeled salad dressing		day items will be consider	•	
	were observed in the	refrigerator.		will be discarded. Nursing		
				that any of the residents'	•	
		erim FSM on 10/28/2021 at		items are labeled, dated, a		
		food items in the resident frigerators should have been		name is present. If the res		
	labeled and dated.	rigerators should have been		discarded. Facility Socia		
	labeled and dated.			Activities Director conduct		
	Interview with the Die	tary Manager (DM) on		with the facility resident co	•	
	Interview with the Dietary Manager (DM) on 10/29/2021 at 12:40 PM revealed he was			re-educated on the proper		
		aining the refrigerators in the		food items stored in the fa	•	
		rooms and all staff were		nourishment rooms. This		
		ng and dating food brought		completed on 12/10/21	-	
	in from outside the fa	cility. The DM stated he		All dining staff and nursin	g staff, including	
		ely long hours in the kitchen		agency received education		
	and did not get to his			Manager and Regional Cl		
	resident nourishment	rooms.		regarding proper labeling, discarding expired food ite		

Facility ID: 923538

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING			l	C 40/2024	
NAME OF P	ROVIDER OR SUPPLIER	040400	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	11/	10/2021	
	10115211 011 001 1 21211				30 WEST SUGAR CREEK ROAD			
SATURN I	NURSING AND REHABIL	ITATION CENTER			HARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 812	Continued From page 66 The Administrator stated in an interview on 10/29/2021 at 2:10 PM that the dietary department should be checking the nourishment room refrigerators daily for cleanliness, food labeling, dating, and temperature.		FE	# - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. Executive Director and/or Dietary Manager will inspect the facility Nourishment Rooms, including refrigerators and food storage areas to ensure that food items has been labeled with an open date, resident name, and has been discarded timely. These audits will be completed 2 times a week for 2 weeks, then weekly for 2 weeks. An audit tool titled "Food Storage" was developed		ates ed. ed its		
					to record these results.  Executive director and/or dietary Mana will complete a summary of audit result and present at the facility monthly Qua Assurance Performance Improvement Committee meetings times three month where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.  #5 – Compliance Date: 12/10/2021	ts lity		